

may be retained by the hospital or attending physician.
UNLAWFUL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1384

CERTIFICATE OF DEATH

01358

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN lb 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 09X22 Hurlock			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		d. STREET ADDRESS Not given		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First George	Middle 	Last Anderson	4. DATE OF DEATH 2	Month 26	Day Year 1957
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Not given		9. AGE (In years last birthday) 61	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Cannery		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U. S.	
13. FATHER'S NAME Not given				14. MOTHER'S MAIDEN NAME Not given			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Crownsville State Hospital Hospital Records Cambridge Hospital		INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 610 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)							
Prostatic Hypertrophy with urinary retention							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Generalized and cerebral arteriosclerosis, Right hemiplegia							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. n. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from alive on 2/25 1957 and that death occurred at 10:00 AM , from the causes and on the date stated above.		2/25, 1957, to 2/26 1957					
ACTUAL SIGNATURE <i>Lionel McHenry Mapp.</i>		ADDRESS (Street, city or town, state) Crownsville, Md.					
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, Md.		DATE SIGNED 2/26/57					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/2/57		22c. NAME OF CEMETERY OR CREMATORIUM Church Cemetery		22d. LOCATION (City, town, or county) Pocomoke City, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J.E. Stewart Funeral Home, Salisbury, Md.		24a. REC'D BY REGISTRAR MAR 5 1957					
		24b. REGISTRAR'S SIGNATURE X. M. Joyce					

RECEIVED - CIVILIAN CO. DEATH

BUREAU V. S.

MAR 4 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1350

CERTIFICATE OF DEATH

01359
21

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the Burial-Transit Permit. Then please remove carbon papers. Post Card 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia		b. COUNTY Elizabeth City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hampton		d. STREET ADDRESS 3911 Shell Ave.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wilson Rd.				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First BERNARD	Middle JAMES	Last APPERSON	SR	4. DATE OF DEATH	Month FEBRUARY	Day 1	Year 1957
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH May 8, 1877	9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months 79	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Furniture		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Eli Arperson				14. MOTHER'S MAIDEN NAME Mary K. Davenport					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 272 09 1889		17. INFORMANT Mrs Robert E. Coleman-Daughter - Annapolis, Md.		Address Wilson Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 177X		<i>Cancer of prostate c metastasis</i>				INTERVAL BETWEEN ONSET AND DEATH 77 yrs.			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. DUE TO		(b)							
DUE TO		(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 420. arteriosclerotic CVD c angina						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m.	Month 11	Day 1	Year 1957	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.)	20f. (City or town) Hampton	(County) Hampton	(State) Virginia	
21. I certify that I attended the deceased from 1/1/1957 to 1/1/1957 , that I last saw the deceased alive on 1/1/1957 , and that death occurred at 44 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Frank M. Shipley M.D.									
DATE SIGNED February 2, 1957									
ACTUAL SIGNATURE Frank M. Shipley M.D.									
PHYSICIAN'S NAME (Type) Frank Shipley									
63 College Ave. Annapolis, Maryland									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-5-57	22c. NAME OF CEMETERY OR CREMATORIUM Oakland Cemetery		22d. LOCATION (City, town, or county) Hampton, Virginia		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home		ADDRESS Annapolis, Md.		24a. REC'D BY REGISTRAR FER 5 10		24b. REGISTRAR'S SIGNATURE Wm. J. French			

BUREAU V. S.

FEB 5 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01360
- 74

Reg. Dist. No.

1385

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Same	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena		c. LENGTH OF STAY IN lb 40 y.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Boulevard Park		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Same	
3. NAME OF DECEASED (Type or print) Vincent Henry Bailey		d. STREET ADDRESS / Same	
4. DATE OF DEATH February 13th,		Month 19	Day 57
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 4/17/06
9. AGE (In years last birthday) 50 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Westinghouse Electronic Dept.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Jacob Bailey		14. MOTHER'S MAIDEN NAME Josephine Skipper	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-24-1273	
17. INFORMANT Mr. Thomas Bailey (brother)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO ? INTERVAL BETWEEN ONSET AND DEATH Sudden			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Gustave H. Faubert, M.D.</i>		DATE SIGNED 2/14/57	
EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 16, 57	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Mt. Carmel Cemetery		22d. LOCATION (City, town, or county) (State) Mt. Rd. Anne Arundel, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Richard J. Faubert, Jr.</i>		24a. REC'D BY REGISTRAR B 18 1957	
		24b. REGISTRAR'S SIGNATURE L. J. DeAlba	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

WEDDING CERTIFICATE OF DEATH

2000

DECEASED

FEB 18 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Part 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Part 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1351 CERTIFICATE OF DEATH

01361

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Annapolis</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>C. A. General</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Joseph</i>	Middle <i>S.</i>	Last <i>Bean</i>
4. DATE OF DEATH <i>Oct. 23 1957</i>	Month <i>Oct.</i>	Day <i>23</i>	Year <i>1957</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-13-1829</i>
9. AGE (In years lost birthday) <i>77 yrs.</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Bet Contractor</i>	11. KIND OF BUSINESS OR INDUSTRY <i>Bulding Homes</i>	12. BIRTHPLACE (State or foreign country) <i>Baltimore Md. U.S.A</i>
13. FATHER'S NAME <i>Joseph Bean</i>	14. MOTHER'S MAIDEN NAME <i>Elizabeth Stevens</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <i>Margaret L. Bean</i>	Address <i>(2)</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute myocardial infarction</i> DUE TO <i>420.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>2/22</i> , 19 <i>57</i> , to <i>2/23</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>2/23</i> , 19 <i>57</i> , and that death occurred at <i>NOON</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John L. Hedeman</i>	PHYSICIAN'S NAME (Type) <i>JOHN HEDEMAN</i>	ADDRESS <i>90 CATHEDRAL ST. ANNAPOLIS MD.</i>	DATE SIGNED <i>2/23/57</i>
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>2-26-1957</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>ST. ANNE'S CEMETERY</i>	22d. LOCATION (City, town, or county) <i>ANNAPOLIS</i> (State) <i>MARYLAND</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Son Annapolis MD</i>		ADDRESS <i>226 REG'D BY REGISTRAR DATE 2/25/57</i>	24e. REGISTRAR'S SIGNATURE

MANUFACTURED BY THE NATIONAL SECURITY COUNCIL

CERTIFICATE OF DATA

1957

BUREAU V. 2

FEB 27 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01362

1386

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY A.A. County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MD. b. COUNTY A.A. County						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linthicum Hgts.	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linthicum Hgts.						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 551 Shipley Rd	d. STREET ADDRESS 551 Shipley Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Minnie Louise Berry	First	Middle	Last					
4. DATE OF DEATH Feb. 23, 1957	Month	Day	Year 19					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 24, 1889					
9. AGE (In years last birthday) 67 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home						
11. BIRTHPLACE (State or foreign country) Jamesville, N.C		12. CITIZEN OF WHAT COUNTRY?						
13. FATHER'S NAME John H. Bailey	14. MOTHER'S MAIDEN NAME Fannie Calloway							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) none	16. SOCIAL SECURITY NO.	17. INFORMANT John H. Berry, 551 Shipley Rd.	Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO 260X								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardio-vascular disease DUE TO 260.1								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) (c) Diabetes Mellitus								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 420.1	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Baltimore	(County) Baltimore	(State) Maryland
21. I certify that I attended the deceased from Nov. 10, 1943, to Feb. 23, 1957, that I last saw the deceased alive on Feb. 22, 1957, and that death occurred at 7:00 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE George A. Knipp M.D. 4116 Edmondson Avenue DATE SIGNED 2/25/57								
PHYSICIAN'S NAME (Type) George A. Knipp, M. D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-27-57	22c. NAME OF CEMETERY OR CREMATORIAL Meadow Ridge	22d. LOCATION (City, town, or county) Howard County					
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		ADDRESS 4107 Wilkens Ave	24a. REC'D BY REGISTRAR DATE FEB 27 1957	24b. REGISTRAR'S SIGNATURE H. H. Hubbard				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF STATE
CABLEGRAM TO BRAZIL

1951

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BUREAU Y.

FEB 27 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1387

CERTIFICATE OF DEATH

Req. Dist.

Q1363

1. PLACE OF DEATH a. COUNTY		ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		a. STATE Md.					
Crownsville, Md.		9 days.		b. COUNTY AA					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)							
CROWNSVILLE STATE HOSPITAL		BALTIMORE 3V-14							
3. NAME OF DECEASED (Type or print)		First ROBERT	Middle	Last BILLUPS	4. DATE OF DEATH				
5. SEX M		6. COLOR OR RACE Col.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Jan. 12, 1900	9. AGE (In years lost birthday) 57 yrs.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm hand		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Va.	12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME Thomas Billups		14. MOTHER'S MAIDEN NAME Mary (MN) Unl...cm							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -		16. SOCIAL SECURITY NO.		17. INFORMANT Address					
				Horace Billups 2402 Lakeview Av.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS									
420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) HYPERTENSIVE ARTERIOSCLEROTIC									
DUE TO (c) CARDIOVASCULAR DISEASE									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from 1-24, 1957, to 2-1-, 1957, that I last saw the deceased alive on 2-1-, 1957, and that death occurred at 7:15 P.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <u>L. Benedict, M.D.</u>						M.D. CROWNNSVILLE STATE HOSPITAL			
PHYSICIAN'S NAME (Type) L. BENEDICT M.D., CROWNNSVILLE									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVED</u>		22b. DATE THEREOF Feb. 3, 1957		22c. NAME OF CEMETERY OR CREMATORIAL Rise Valley		22d. LOCATION (City, town, or county) Gloucester Co., Va.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE						24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
L. M. JOSEPH						FEB 5 1957		<u>L. M. Joseph</u>	

PUEBLA V. 3

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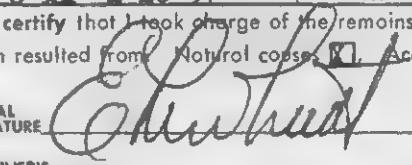
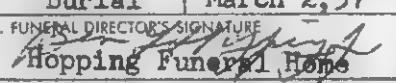
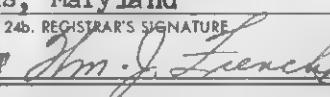
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01364

Reg. Dist. No. 21

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		d. STREET ADDRESS 113 Main Street		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 113 Main Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) GEORGE		First	Middle	Last	4. DATE OF DEATH February 28	Month	Day	Year
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Sept 17, 1890	9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Plumber		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov.		11. BIRTHPLACE (State or foreign country) Lansing, Mich		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME John David A. Blay				14. MOTHER'S MAIDEN NAME John Lydia Vernetta				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none		17. INFORMANT Mr W. Garrett Larrimore - Daughter-Edgewater, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Disease INTERVAL BETWEEN ONSET AND DEATH 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Natural Causes								
20c. TIME OF INJURY Month, Day, Year Hour a.m. 6 p.m. 2-28-57 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> ACTUAL SIGNATURE  EXAMINER'S NAME (Type) Elmer G. Linhardt DATE SIGNED February 28, 1957								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 2, 57		22c. NAME OF CEMETERY OR CREMATORIUM St. Anne's Cemetery		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE 		ADDRESS Annapolis, Md.		24a. REC'D BY REGISTRAR DATE 1957		24b. REGISTRAR'S SIGNATURE 		

REGEAU V. G.

1057

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01365

Reg. Dist. No. 22

1388

1. PLACE OF DEATH a. COUNTY Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Prince Georges						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Odenton		c. LENGTH OF STAY IN lb Few seconds		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 175				d. STREET ADDRESS 5103 2nd Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First George Louis	Middle Bollinger	Last	4. DATE OF DEATH February 24th.	Month	Day	Year		
5. SEX M	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 12/1/13	9. AGE (in years from birthday) 43 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pittsburg, Pa.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME William A Bollinger				14. MOTHER'S MAIDEN NAME Sadie Tranc						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes			16. SOCIAL SECURITY NO.		17. INFORMANT Automobile operator's license			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture of skull DUE TO Conditions, if any, which gave rise to immediate cause (b) Comp. and comm. fratures of msndible and maxillar " " DUE TO (c) Comp and comm. fratures of ulnar and radius " " PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Crushed chest. Multiple lacerations of face,									INTERVAL BETWEEN ONSET AND DEATH Sudden	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.									20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Collided with another automobile	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Hour a.m. 12.10 P.M.		Month, Day, Year 2/24/57	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 175	20f. (City or town) Odenton	(County) A.A.	(State) Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE <i>Gustave H. Faubert</i> DATE SIGNED EXAMINER'S NAME (Type) Gustave H. Faubert M.D.										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/28/57	22c. NAME OF CEMETERY OR Crematory Arlington National	22d. LOCATION (City, town, or county) Arlington Va.	(State)						
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.			24a. REC'D BY REGISTRAR FEB 28 1957	24b. REGISTRAR'S SIGNATURE <i>John Taylor</i>						

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
FURTHER INFORMATION: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

UPPEAU Y.

1957



INSTRUCTIONS

TO ENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be submitted within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

This bottom copy may be retained by the hospital or attending physician.

VS AISC 1-55 JUN

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01366

CERTIFICATE OF DEATH

1389

Reg. Dist. No. 28

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN		MARYLAND LENGTH OF STAY (In this place)		STATE Md. CITY (If outside corporate limits, write RURAL and give nearest town) TOWN	
Anne Arundel Millersville (Rural)		59 yrs.		Anne Arundel Millersville,	
HOSPITAL OR INSTITUTION OR STREET ADDRESS			STREET ADDRESS (If rural give location)		
Woodland & Pasadena Rds.			Woodland & Pasadena Rds.		
3. NAME OF DECEASED (First) Charles (Middle) Bolm (Last)			4. DATE OF DEATH Feb. 10 19 57		
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Nov. 24, 1897	9. AGE last birthday 59 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Millworker			10b. KIND OF BUSINESS OR INDUSTRY Wurzberger Co.	11. BIRTHPLACE (State or foreign country) Pasadena, Md.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Charles Bolm			14. MOTHER'S MAIDEN NAME Eleanor Meyers		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, unk.) No			16. SOCIAL SECURITY NO. 216-03-5605	17. INFORMANT & ADDRESS Mrs Margaret Bolm, same as 2	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
IMMEDIATE CAUSE <input checked="" type="checkbox"/> Carcinoma of the Throat		(A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 2 years	
ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION 1956		19b. MAJOR FINDINGS OF OPERATION Carcinoma of Throat		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from... for ... to ... , that I last saw the deceased alive on ... , and that death occurred at ... P.M., from the causes and on the date stated above.					
SIGNATURE James S. Bealeyslee M.D. 108 Central Ln Glen Burnie, Md. 2/12/57					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Feb. 13 1957		NAME OF CEMETERY OR CREMATORIUM Glen Haven Memorial	
24. REC'D BY REGISTRAR DATE 2/14/57		REGISTRAR'S SIGNATURE Matthew M. Joyce		LOCATION (City, town, or county) Glen Burnie, Md.	
				ADDRESS	
				25. FUNERAL DIRECTOR'S SIGNATURE Hopper, <i>[Signature]</i> , Glen Burnie, Md.	



200

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01367

1390

CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewater		c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Edgewater			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pine Wiff Beach		d. STREET ADDRESS Pine Wiff Beach			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First LILLIAN	Middle H	Brashears	4. DATE OF DEATH Month FEBRUARY Day 15, Year 57	Month 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 16, 1876	9. AGE (In years lost birthday) 80 yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Abraham Hirsch			14. MOTHER'S MAIDEN NAME Babette Lehman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 220-07-9351	17. INFORMANT Mrs Bertha Schelley- Sister- Same as # 2	Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 171X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO carcinoma of cervix					INTERVAL BETWEEN ONSET AND DEATH 6 mos.	
DUE TO carcinomatosis						
(c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Annapolis	(County) Anne Arundel	(State) Maryland
21. I certify that I attended the deceased from 1/20/57 , 19, to 2/15/57 , 19, that I last saw the deceased alive on 2/14/57 , 19, and that death occurred at 10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Amos Garrett Blvd., Annapolis, Maryland DATE SIGNED 2/16/57						
ACTUAL SIGNATURE <i>S. Borssuck</i>		M.D.				
PHYSICIAN'S NAME (Type) S. Borssuck MD		Amos Garrett Blvd., Annapolis, Maryland				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 18, 1957	22c. NAME OF CEMETERY OR CREMATORIAL Fort Lincoln	22d. LOCATION (City, town, or county) Prince George County, Maryland (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. J. French</i>		ADDRESS HOPPING FUNERAL HOME ANNAPOLIS, MARYLAND	24a. REC'D BY REGISTRAR DATE 2/16/57 24b. REGISTRAR'S SIGNATURE <i>J. J. French</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page **1** may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page **2** should be detached for use as the burial-transit permit. Then please remove carbon papers. Page **1** and **2** should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

Y. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 12 11-11-2-25-57 et

01368

1391

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Part 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Part 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

1. PLACE OF DEATH a. COUNTY A.A.		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY A.A.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forest Glen	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forest Glen				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)	First LENA BROOKS	Middle	Last			
4. DATE OF DEATH 2/18/57	Month	Day	Year 19			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/18/60	9. AGE (In years from birthday) 90 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Germany	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Gottlieb Dais		14. MOTHER'S MAIDEN NAME ?				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	17. INFORMANT Family - Same	Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Cardio-vascular disease</i>				INTERVAL BETWEEN ONSET AND DEATH <i>2 years</i>		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Fracture of the left hip</i>						
DUE TO (c) <i>January 10, 1955</i>						
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Fracture of the left hip - January 10, 1955</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i>February 17, 1957</i>				
20c. TIME OF INJURY Hour a.m. 19 p.m.	Month	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Glen Haven	20f. (City or town) (County) (State) Baltimore
21. I certify that I attended the deceased from <i>January 10, 1957</i> , to <i>February 18, 1957</i> , that I last saw the deceased alive on <i>February 17, 1957</i> , and that death occurred at <i>10:15 A.M.</i> from the causes and on the date stated above.						
ACTUAL SIGNATURE <i>R. M. McLaughlin</i>	M.D.			ADDRESS (Street, city or town, state) <i>Mountain Road, Pasadena, Md. Feb. 18, 1957</i>		
PHYSICIAN'S NAME (Type) <i>R. M. McLaughlin</i>	DATE SIGNED					
22a. BURIAL, CREMATION, REMOVAL (Specify) B	22b. DATE THEREOF 2/22/57	22c. NAME OF CEMETERY OR CREMATORIAL Glen Haven	22d. LOCATION (City, town, or county) Baltimore	(State)		
23. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Homes - 130 E. Fort Ave.			24a. REC'D BY REGISTRAR FEB 20 1957	24b. REGISTRAR'S SIGNATURE <i>L. J. Delong</i>		
ADDRESS			DATE			

BUREAU V.

FEB 20 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1392

CERTIFICATE OF DEATH

01369
28

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 4 yrs. 4 mos. 24 days Baltimore City	
d. NAME OF HOSPITAL (If not in hospital, give street address) Q4 INSTITUTION Crownsville State Hospital		d. STREET ADDRESS 3425 Piedmont Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Edith	Middle	Last Brown
4. DATE OF DEATH	Month 2	Day 23	Year 1957
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/31/96
9. AGE (In years less birthday) 60 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Benjamin Green		14. MOTHER'S MAIDEN NAME Lucinda Green	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO Unk.	
17. INFORMANT Hospital Records		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia DUE TO 442X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) Cerebrovascular Accident - probably Thrombosis DUE TO (c) Hypertensive Cardiovascular Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Nephrosclerosis	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/5, 1957, to 2/23, 1957, that I last saw the deceased alive on 2/20, 1957, and that death occurred at 4:15 a.m., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Crownsville, Md.	
ACTUAL SIGNATURE Lionel McHenry Mapp, M. D.		DATE SIGNED 2/23/57	
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 28, 1957	
22c. NAME OF CEMETERY OR CREMATORIAL Balto. National Cem.		22d. LOCATION (City, town, or county) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Mrs. Katie R. Williams		ADDRESS 322 N. DATE FEB 28 1957	
		24a. REC'D BY REGISTRAR L. M. Joyce	
		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be retained by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 9/55

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3 08 1957



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 File No. 32-657 et al

Item 9 File No. 32-657 et al

CERTIFICATE OF DEATH

Reg. Dist. No.

01370

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Part 2 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Part 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE	
<i>Anne Arundel MARYLAND</i>		<i>Maryland A.C.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>Annapolis</i>		<i>Annapolis</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) or INSTITUTION		d. STREET ADDRESS	
<i>A.C. General Hosp.</i>		<i>402 Chester Ave.</i>	
3. NAME OF DECEASED (Type or print)	First <i>Florence</i>	Middle <i>Brown</i>	Last 4. DATE OF DEATH <i>2 5 1957</i>
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-13-1894</i>
<i>Female</i>	<i>Cbl.</i>		9. AGE (In years last birthday) <i>62 yrs.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<i>Domestic</i>		<i>Lothian, Md.</i>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Lothian, Md.</i>		<i>U.S.A.</i>	
13. FATHER'S NAME	14. MOTHER'S MAREN NAME		
<i>Thomas Johnson</i>	<i>Delia Johnson</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
<i>No</i>		<i>Ethelia Johnson</i>	<i>402 Chester Ave.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			
<i>Cerebral Hemorrhage</i>			
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)			
Arteriosclerosis			
DUE TO			
(c) Sombly			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
19		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Annapolis, Md.</i>	
20f. (City or town) <i>Annapolis, Md.</i>		(County) (State)	
21. I certify that I attended the deceased from <i>1-21-57</i> , 19 <i>57</i> , to <i>2-3-57</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>2-2-57</i> , 19 <i>57</i> , and that death occurred at <i>11 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>G.T. Abo</i>		ADDRESS (Street, city or town, state) <i>122 Cochedale St Annapolis</i>	
PHYSICIAN'S NAME (Type) <i>G.T. Abo</i>		DATE SIGNED <i>2-4-57</i>	
22a. BURIAL, CREMATION OR REMOVAL (Specify)		22b. DATE THEREOF	
<i>Burial 2-7-57</i>		<i>Brewer Hill</i>	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR DATE <i>2/10/57</i>	
<i>William Keese - Annapolis, Md.</i>		24b. REGISTRAR'S SIGNATURE <i>Mr. Jim French</i>	

150.

150. *Leucosticte taeniata* (Vigors) *taeniata* (Vigors)
♂. A. S. 1880. 1880. 1880.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01371

1393

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Anne Arundel</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort George G. Meade</u>		c. LENGTH OF STAY IN 1b <u>2 Feb 57</u>		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort George G. Meade</u>		e. STREET ADDRESS <u>162 D</u>									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. Army Hospital</u>				d. STREET ADDRESS <u>162 D</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>RODRICK</u>		First <u>I</u>	Middle <u></u>	Last <u>BROWN</u>	4. DATE OF DEATH <u>February 7 1957</u>	Month <u>February</u>	Day <u>7</u>	Year <u>1957</u>							
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>25 May 1942</u>	9. AGE (In years last birthday) <u>14 yrs.</u>	IF UNDER 1 YEAR <u>Months</u>	IF UNDER 24 HRS. <u>Days Hours Min.</u>								
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>									
13. FATHER'S NAME <u>Woodrow Wilson Brown</u>		14. MOTHER'S MAIDEN NAME <u>Barbara Edith Pope</u>		Address											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic glomerulonephritis with uremia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Dunbarville Rd</u>		20f. (City or town) <u>Dunbarville Rd</u>		(County) <u>Baltimore Co</u>		(State) <u>Md</u>	
21. I certify that I attended the deceased from <u>2 Feb</u> , 19 <u>57</u> , to <u>7 Feb</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7 Feb</u> , 19 <u>57</u> , and that death occurred at <u>0630 AM</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		DATE SIGNED											
ACTUAL SIGNATURE <u>Sgt H. Tararish</u>		M.D. USAH, FGGM, Md.		<u>7 Feb 57</u>											
PHYSICIAN'S NAME (Type) <u>SAID H. TARARISH</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Feb 1957</u>		22b. DATE THEREOF <u>Feb 1957</u>		22c. NAME OF CEMETERY OR CREMATORIUM <u>Larson Valley</u>		22d. LOCATION (City, town, or county) <u>Dunbarville Rd</u>		(State) <u>Md</u>					
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Ridgley Selby, Laurel, Md</u>		24b. REC'D BY REGISTRAR <u>W. L. Taylor</u>		24c. REGISTRAR'S SIGNATURE <u>W. L. Taylor</u>		DATE <u>7 Feb 57</u>									

MEAU V. S.

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REGEV ET AL

INSTRUCTIONS

TO ENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed with the registrar within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01372

CERTIFICATE OF DEATH

1394

Reg. Dist. No. 72

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	Anne Arundel Severn	MARYLAND LENGTH OF STAY (in this place)	STATE Maryland CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
HOSPITAL OR INSTITUTION OR STREET ADDRESS	23 years X0 Severn		
3. NAME OF (Type or Print)	(First) Roy	(Middle) Richard	(Last) Burns
5. SEX	6. COLOR OR RACE	7. SINGLE MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
Male	White	Married	Jan. 27, 1889
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Waiter (ret.)	Elite Laundry	Baltimore, Md.	U.S.A.
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
Nathan T. Burns	Annie L. Sheriff		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS	INTERVAL BETWEEN ONSET AND DEATH
No	215-03-5074	Mrs. Roberto Burns Same as t	3 mos
18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)		Cerebral Hemorrhage Hypertensive Cardiovascular Disease	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town)	(County) (State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from AUGUST 1953 to Feb. 1957, that I last saw the deceased alive on Feb. 8, 1957, and that death occurred at 11:55 p.m., from the causes and on the date stated above.			
SIGNATURE Charles R McDonald		ADDRESS (Street, city, town, state) Glen Burnie Md	DATE SIGNED 2-16-57
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORIUM	LOCATION (City, town, or county) Baltimore, Md.
Burial	Feb. 19, 1957	Loudon Park Cemetery	(State)
24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	
REC'D BY REGISTRAR FEB 19 1957	Clara Hadley	P.W. Livingston Glen Burnie, Md.	

S' A II

MONDAY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01373

1354

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY Anne Arundel			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) City			b. COUNTY AA		
c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis, Maryland		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Annapolis, Md.			d. STREET ADDRESS 74 South Gate Avenue		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Albert	Middle Edward	Last CARONNA	4. DATE OF DEATH February 14 1957
5. SEX M	6. COLOR OR RACE CAU.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/19/11	9. AGE (In years lost birthday) 45 yrs	10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) USN Ret.		10b. KIND OF BUSINESS OR INDUSTRY Musician	11. BIRTHPLACE (State or foreign country) N.Y.	12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Lewis Caronna			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes			16. SOCIAL SECURITY NO. 1928-1955	17. INFORMANT USNH Records	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombotic Thrombocytopenic Purpura 296X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m.	Month 19	Day 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1-23, 1957, to 2-14-, 1957, that I last saw the deceased alive on 2-14-57, 1957, and that death occurred at 8:45 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE Vincent P. Butler, Jr. PHYSICIAN'S NAME (Type) V.P. BUTLER JR ADDRESS LT MC U.S. Navy 22d. LOCATION (City, town, or county) Annapolis, Md. (State)					
22e. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-18-57	22c. NAME OF CEMETERY OR CREMATORIUM St. Mary's	22d. LOCATION (City, town, or county) Annapolis, Md. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home			24a. REC'D BY REGISTRAR FEB 19 1957	24b. REGISTRAR'S SIGNATURE John G. French	

DURKAU V. S

1957



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1355

CERTIFICATE OF DEATH

Reg. Dist. No.

01374

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Resided before admission) b. STATE <i>Maryland</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN TB <i>Annapolis</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Skidmore, Md.</i>		e. STREET ADDRESS <i>15 St. S. Annapolis</i>				
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)	First <i>Ernest</i>	Middle <i>Edward</i>	Last <i>Carr</i>			
4. DATE OF DEATH	Month <i>3</i>	Day <i>2</i>	Year <i>1957</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Col.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>4-28-1918</i>			
9. AGE (In years with birthday) <i>38 yrs.</i>	10. IF UNDER 1 YEAR Months <i>3</i>	11. IF UNDER 24 HRS. Days <i>2</i>	12. IF UNDER 24 HRS. Hours <i>Min.</i>			
10a. USUAL OCCUPATION (Give kind of work done during most working life, even if retired) <i>Labourer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Experimental</i>				
10c. BIRTHPLACE (State or foreign country) <i>Skidmore, Md.</i>		11. CITIZEN OF WHAT COUNTRY <i>U. S. A.</i>				
13. FATHER'S NAME <i>William J. Carr</i>		14. MOTHER'S MAIDEN NAME <i>Ella Cromwell</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Work</i>		16. SOCIAL SECURITY NO. <i>Ella Carr - Pt 2 B-416 Annap. Md.</i>				
17. INFORMANT <i>Address</i>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>3 hr.</i>				
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. pt. p. m. 19	Month, Day, Year 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Skidmore</i>	20f. (City or town) <i>Skidmore</i>	(County) <i>Baltimore</i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from alive on <i>1/2 1957</i> to <i>2/3 1957</i> , that I last saw the deceased and that death occurred at <i>M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>32 Labor St. Annapolis</i>		DATE SIGNED <i>2/3/57</i>		
ACTUAL SIGNATURE <i>Theodore J. Johnson</i>		PHYSICIAN'S NAME (Type) <i>M.D.</i>				
22a. BURIAL, CREMATION / REMOVAL (Specify) <i>Cremation</i>	22b. DATE THEREOF <i>2-5-57</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Broadneck</i>	22d. LOCATION (City, town, or county) <i>Skidmore</i>	(State) <i>Md.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>William French</i>	ADDRESS <i>Annapolis, Md.</i>	24a. REC'D BY REGISTRAR <i>FEB 4 1957</i>	24b. REGISTRAR'S SIGNATURE <i>J. M. French</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 1 to be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Remove and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1356

CERTIFICATE OF DEATH

Reg. Dist. No.

01375
21

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND	2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riva X		d. STREET ADDRESS /
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital					e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3 NAME OF DECEASED (Type or print)	First HARRISON	Middle C	Last CARR	4. DATE OF DEATH FEBRUARY 7 1957	Month Day Year
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 18, 1869	9. AGE (in years last birthday) 87 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Farmer	11. BIRTHPLACE (State or foreign country) Baltimore Co., Md.	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Amos C. Carr		14. MOTHER'S MAIDEN NAME Mary Lancaster			Address
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none	17. INFORMANT Mrs Benjamin Carr-- Daughter- same as # 2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. 422.1 (b) Atherosclerotic Cardiovascular Disease Unknown DUE TO (c)					
INTERVAL BETWEEN ONSET AND DEATH 8 wks.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Millersville	(County) Maryland
21. I certify that I attended the deceased from 1 February 1957 , to 7 February 1957 , that I last saw the deceased alive on 7 February 1957 , and that death occurred at 2:15 P.M. , from the causes and on the date stated above.					
ACTUAL SIGNATURE Edward S. Beck		ADDRESS (Street, city or town, state) 44 Southgate Ave., Annapolis, Md.			
PHYSICIAN'S NAME (Type) Edward S. Beck		DATE SIGNED 2/11/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-9-1957	22c. NAME OF CEMETERY OR CREMATORIAL Baldwin Memorial	22d. LOCATION (City, town, or county) Millersville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home		24a. REC'D BY REGISTRAR DATE FEB 11 1957			
		24b. REGISTRAR'S SIGNATURE J. French			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
it should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 2 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S

FEB 11 1968

U.S. GOVERNMENT
PRINTING OFFICE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1395

CERTIFICATE OF DEATH

01376

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE <i>MARYLAND</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Maryland</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural, Annapolis</i>			c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		
			d. STREET ADDRESS <i>Rural, Annapolis</i>		
			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First <i>EARL</i>	Middle <i>JAMES</i>	Last <i>CASSADY</i>	4. DATE OF DEATH Month <i>2</i> Day <i>21</i> Year <i>1957</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12/19/1883</i>	9. AGE (In years lost birthday) <i>73 yrs.</i>	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Guard U.S.N.E.T.S.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Guard (net.)</i>	11. BIRTHPLACE (State or foreign country) <i>Michigan</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Unk.</i>			14. MOTHER'S MAIDEN NAME <i>Unk.</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO. <i>W.W. 1</i>	17. INFORMANT <i>Mary E. Cassady #2</i>	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>multiple cerebral vascular accidents</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs.</i>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>27A</i>	(County) <i>MD</i> (State) <i>1957</i>
21. I certify that I attended the deceased from <i>2/20</i> , 19 <i>57</i> , to <i>2/27</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>2/20</i> , 19 <i>57</i> , and that death occurred at <i>27A</i> M, from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>John H. Hedeman</i>		ADDRESS (Street, city or town, state) <i>90 Cathedral St</i> DATE SIGNED <i>2/23/57</i>			
PHYSICIAN'S NAME (Type) <i>JOHN HEDEMAN</i>		90 CATHEDRAL ST ANNAPOLIS MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buri</i>	22b. DATE THEREOF <i>2/25/57</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Annapolis Nat'l.</i>	22d. LOCATION (City, town, or county) <i>Annapolis, Md.</i> (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor and Sons</i>			24a. REC'D. BY REGISTRAR <i>5823 1500</i>	24b. REGISTRAR'S SIGNATURE <i>John Drueck</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 41
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, part 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Part 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

URÉAU V. S.

FEB 27 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01377

1357

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		
<i>A. A.</i> MARYLAND		Ind. <i>A. H.</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	b. COUNTY		
<i>Annapolis</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<i>A. A. Gen. Hospital</i>	<i>Skidmore</i>			
3. NAME OF (Type or print)	First <i>Gregory</i>	Middle <i>Chambers</i>	4. DATE OF DEATH Feb. Month Day Year <i>19 57</i>	
S. SEX <i>Male</i>	6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 10 1937</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Annapolis Ind</i>	12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Houston Chambers</i>	14. MOTHER'S MAIDEN NAME <i>Carline Henson</i>	Address <i>Carline Henson Skidmore</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>053.4</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <i>(b)</i> DUE TO <i>(c) Septicemia</i>	INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Hour o. m. p. m.	Month, Doy, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Febr. 7, 1957</i> to <i>Febr. 8, 1957</i> , that I last saw the deceased alive on <i>Febr. 8, 1957</i> , and that death occurred at <i>1:30 AM</i> , from the causes and on the date stated above.				
ACTUAL SIGNATURE <i>Clayton Norton</i>	ADDRESS (Street, city or town, state) <i>95 Cathedral St. M.D.</i>			DATE SIGNED <i>2/9/57</i>
PHYSICIAN'S NAME (Type) <i>CLAYTON NORTON</i>	22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Feb 10, 1957 Broadneck</i>			
22b. DATE THEREOF <i>Feb 10, 1957</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Broadneck</i>	22d. LOCATION (City, town, or county) <i>St. Margarets Ind</i>	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Anne Johnson Annapolis</i>	ADDRESS <i>Anne Johnson Annapolis</i>	24a. REC'D BY REGISTRAR DATE <i>2/14/57</i>	24b. REGISTRAR'S SIGNATURE <i>Mr. Wm J. French</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

LIBRARY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01378

Reg. Dist. No.

1396

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Part 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Part 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore City		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN lb 14 yrs. 8 mos. 23 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City		d. STREET ADDRESS 933 Pennsylvania Avenue		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS 933 Pennsylvania Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First Mary	Middle E.	Last Clements	4. DATE OF DEATH 1957	Month 2	Day 10	Year 1957	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1887?	9. AGE (In years from birthday) 69? yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Not given		12. CITIZEN OF WHAT COUNTRY? U. S.		
13. FATHER'S NAME Not given				14. MOTHER'S MAIDEN NAME Not given				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Hospital Records		Crownsville State Hosp. Crownsville, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute Renal Failure DUE TO (c) Hypertensive cardiovascular renal disease								
INTERVAL BETWEEN ONSET AND DEATH								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypostatic Pneumonia								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 1/28 , 1957, to 2/10 , 1957, that I last saw the deceased alive on 2/8 , 1957, and that death occurred at 5:15 PM , from the causes and on the date stated above.								
ADDRESS (Street, city or town, state)								
DATE SIGNED 2/11/57								
ACTUAL SIGNATURE Lionel McHenry Mapp, M. D.								
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.		22d. LOCATION (City, town, or county) Baltimore, Md.						
22a. BURIAL, CREMATION, REMOVAL (Check) Removal		22b. DATE THEREOF 14 Feb. 56		22c. NAME OF CEMETERY OR CREMATORIUM Univ. of Md. Med. School		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE William Beece II		ADDRESS Annapolis Md.		24a. REC'D BY REGISTRAR DATE 2-18-57		24b. REGISTRAR'S SIGNATURE H. M. Jordon		

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01379

1397

CERTIFICATE OF DEATH

Reg. Dist. No. 78

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville	c. LENGTH OF STAY IN 1b 4yr. 8mos. 17days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital	d. STREET ADDRESS Jersey Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Catherine Middle Lois Collins	4. DATE OF DEATH Month 2 Day 6 Year 1957		
5. SEX Female 6. COLOR OR RACE Negro 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 7/10/05	9. AGE (In years last birthday) 21 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic	10b. KIND OF BUSINESS OR INDUSTRY Housework	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME Fletcher Collins		14. MOTHER'S MAIDEN NAME Mancy Mae West	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] Unk.	16. SOCIAL SECURITY NO. Unk.	17. INFORMANT Hospital Records	Address Crownsville State Hosital Crownsville, Maryland
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4343 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Epileptiform convulsion (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Convulsive disorder of unknown etiology			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month Day Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2/5/57 to 2/6/57, that I last saw the deceased alive on 2/5/57, and that death occurred at 12:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Lionel McHenry M.D.</i>		ADDRESS (Street, city or town, state) Crownsville, Md.	
PHYSICIAN'S NAME (Type) Lionel McHenry, M. D.		DATE SIGNED 2/6/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) 3/10/57	22b. DATE THEREOF 3/10/57	22c. NAME OF CEMETERY OR CREMATORIUM Glass Hill	22d. LOCATION (City, town, or county) Parsonburg
23. FUNERAL DIRECTOR'S SIGNATURE H. Stewart Funeral Home		ADDRESS Talbot St. Salisbury MD	24a. REC'D BY REGISTRAR FEB 19 1957
			24b. REGISTRAR'S SIGNATURE H. M. Joyce

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 8
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1358

CERTIFICATE OF DEATH

01380

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Part 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Part 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>A A</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i>		b. COUNTY <i>A A</i>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>								
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>1217 McKinley St.</i>		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)		First <i>LILLIAN</i>	Middle <i></i>	Last <i>CRANDALL</i>	4. DATE OF DEATH Month <i>2</i> - Day <i>28</i> Year <i>1957</i>							
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>Nov 20-1881</i>	9. AGE (in years lost birthday) <i>73 yrs.</i>	IF UNDER 1 YEAR <input type="checkbox"/>	IF UNDER 24 HRS. <input type="checkbox"/>	Months <i></i>	Days <i></i>	Hours <i></i>	Min. <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Real Est (Ret.)</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Real Estate</i>		11. BIRTHPLACE (State or foreign country) <i>A A Co Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>						
13. FATHER'S NAME <i>Andrew Crandall</i>		14. MOTHER'S MAIDEN NAME <i>Mary Mason</i>										
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input type="checkbox"/> (For, no. or unknown)		16. SOCIAL SECURITY NO. <i>- - - - -</i>		17. INFORMANT <i>Elaine Dawson</i>		Address <i>(2)</i>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>442</i> DUE TO <i>internal chronic cardiac vascular, renal disease in decompensation</i> INTERVAL BETWEEN ONSET AND DEATH <i>1957</i>												
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) DUE TO (c)												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. <i></i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Annapolis</i>		(County) <i>Md.</i>		(State) <i>Md.</i>		
21. I certify that I attended the deceased from <i>Dec 14, 1956 to 2/28, 1957</i> , that I last saw the deceased alive on <i>2/27/57</i> , and that death occurred at <i>10 A.M.</i> from the causes and on the date stated above.												
ADDRESS (Street, city or town, state) <i>Annapolis, Md.</i> DATE SIGNED <i>2/28/57</i>												
ACTUAL SIGNATURE <i>Maurice E. Klawans, M.D.</i>												
PHYSICIAN'S NAME (Type) <i>MAURICE E. KLAWANS, M.D.</i>												
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3-2-57</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Cedar Bluff Cemt</i>		22d. LOCATION (City, town, or county) <i>Annapolis</i>		(State) <i>Md.</i>				
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Taylor Sons</i>		ADDRESS <i>Annapolis Md.</i>		24a. REC'D BY REGISTRAR <i>3/1/57</i>		24b. REGISTRAR'S SIGNATURE <i>J. Taylor Sons</i>						
VS A1S (4) 1SM 9/SS												

UREAU V. 6

3 4 1957



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01381

1398 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>a a</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE <i>M D</i> b. COUNTY <i>A A</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Galesville</i>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X265 Galesville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <i>CHARLOTTE</i>	Middle <i>CROWNER</i>	Last	4. DATE OF DEATH <i>February 28 1937</i>	Month Day Year
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 1890</i>	9. AGE (In years last birthday) <i>68 yrs.</i>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Cumberland Md</i>	
12. CITIZEN OF WHAT COUNTRY? <i>Alice Crowner</i>					
13. FATHER'S NAME <i>Thos. Crownor</i>		14. MOTHER'S MAIDEN NAME		Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO <i>212-18-5645</i>		17. INFORMANT <i>Wife crowner Galesville Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>44</i>		DUE TO <i>Congestive Heart Failure</i>		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i></i>		DUE TO (c) <i></i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.	Month <i>19</i>	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>4-12-19</i> to <i>2-28-19</i> , 19				that I last saw the deceased alive on <i>1-21-19</i> , 19, and that death occurred at <i>3-5-19</i> M, from the causes and on the date stated above.	
ACTUAL SIGNATURE <i>A T ALF</i>		M.D.		ADDRESS (Street, city or town, state) <i>610 Columbia St</i> DATE SIGNED <i>3-1-19</i>	
PHYSICIAN'S NAME (Type) <i>A T ALF</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		22b. DATE THEREOF <i>March 4 1957</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Crowners</i>	
22d. LOCATION (City, town, or county) <i>Galesville</i>				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Benson Murphy Galesville Md</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE	
				24b. REGISTRAR'S SIGNATURE <i>J. French</i>	

BUREAU V. S.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01382
78

1399

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland		b. COUNTY Baltimore City		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN lb lyr. 2 mos. 17 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City		d. STREET ADDRESS 402 Myrtle Avenue		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Winters		First	Middle	Lost	4. DATE OF DEATH Dailey	Month 2	Day 27	Year 19 57
S. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 1/4/89	9. AGE (In years lost birthday) 68 yrs.	IF UNDER 1 YEAR Months 68	IF UNDER 24 HRS Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Fireman		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.		
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Hospital Records		<i>Addressee</i> Crownsville State Hospital Crownsville, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4/20</i>		DUE TO Pneumonia		INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. <i>(b)</i>		DUE TO Senility and generalized arteriosclerosis						
DUE TO <i>(c)</i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cerebral Thrombosis and Aneurism of Aorta							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) Crownsville (State) Md.		
21. I certify that I attended the deceased from 2/26 , 19 57 , to 2/27 , 19 57 , that I last saw the deceased alive on 2/27 , 19 57 , and that death occurred at 5:15 PM , from the causes and on the date stated above.							ADDRESS (Street, city or town, state) Crownsville, Md.	
ACTUAL SIGNATURE <i>Lionel McHenry Mapp.</i>		M.D. Lionel McHenry Mapp, M. D.		DATE SIGNED 2/28/57				
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/3/57		22c. NAME OF CEMETERY OR CREMATORIUM MT. CALVARY CEM.		22d. LOCATION (City, town, or county) Brooksville, Adams Co., Md.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Barbara Wilson</i>		ADDRESS 1000 BRANTLEY AVE.		24a. REC'D BY REGISTRAR DATE 3/1/57		24b. REGISTRAR'S SIGNATURE <i>K. M. Joyce</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Form 13 should be detached for use as the burial/transit permit. Then please remove carbon papers. Form 13 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 9/55

BUREAU V.

JULY 4 1957

REGELVAD

1359

CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Annapolis				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		d. STREET ADDRESS Weems Creek		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Regina	Middle Ellen	Last Dawson	4. DATE OF DEATH February 22 1957	Month Day Year	Day	Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH Feb 8, 1957	9. AGE (in years last birthday) — yrs. Months 15	IF UNDER 1 YEAR Months 15	IF UNDER 24 HRS. Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Annapolis, Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Thomas N. Dawson				14. MOTHER'S MAIDEN NAME Florence R. Garner				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) — — — — —		16. SOCIAL SECURITY NO. — — — — —		17. INFORMANT Thomas N. Dawson - Father - same as # 2		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) Prematurity INTERVAL BETWEEN ONSET AND DEATH								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Annapolis	(County)	(State)	
21. I certify that I attended the deceased from Febr. 8, 1957 , to Febr. 23, 1957 , that I last saw the deceased alive on Febr. 22, 1957 , and that death occurred at 7 A.M. , from the causes and on the date stated above. ACTUAL SIGNATURE Clayton Norton ADDRESS (Street, city or town, state) 95 Cathedral St., Annapolis, Md. DATE SIGNED								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 25, 57	22c. NAME OF CEMETERY OR CREMATORIUM St. Mary's Cemetery		22d. LOCATION (City, town or county) Annapolis, Md. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME		ADDRESS ANNAPOLIS, MD.	24a. REC'D BY REGISTRAR DATE 2/26/57 - D. Russell 24b. REGISTRAR'S SIGNATURE					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, part 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Part 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 1 1957

REGISTRATION

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-5.10W

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18**01384****1360 CERTIFICATE OF DEATH**

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Anne Arundel		MARYLAND		STATE Maryland		COUNTY Anne Arundel	
CITY (If outside corporate limits, write RURAL, OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		STREET ADDRESS 10 Annapolis	
TOWN Annapolis				TOWN Annapolis		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Homewood Conv. Home				STREET ADDRESS 6 Dogwood Rd.			
3. NAME OF DECEASED (First) MARY (Middle) Ann (Type or Print)				4. DATE OF DEATH FEB 25 1957			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Nov. 26 1882	9. AGE last birthday 74	10. MONTHS YRS. 74	11. IF UNDER 1 YEAR Months 0	12. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Melford Jordan				14. MOTHER'S MAIDEN NAME Mary Cummings			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) ---		16. SOCIAL SECURITY NO. -----		17. INFORMANT & ADDRESS George C. Dearth- Son - same as # 2			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 4201 IMMEDIATE CAUSE (A) MYOCARDIAL INFARCTION ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) CORONARY ARTERY SCLEROSIS							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. METASTATIC CARCINOMA OF CERVIX							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, street, office bldg., etc.) 10 Annapolis		21c. WHERE DID INJURY OCCUR? (City or town) (County) Annapolis (State) Md.			
21d. TIME OF INJURY (Month) Feb (Day) 18 (Year) 1957		21e. INJURY OCCURRED While <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? falling down			
22. I hereby certify that I attended the deceased from 2/18/1957 to 2/25/1957, that I last saw the deceased alive on 2/25/1957, and that death occurred at 10:45 AM, from the causes and on the date stated above 2/25/1957							
ADDRESS (Street, city, town, state) 90 Cambridge St. Annapolis, Md. DATE SIGNED 2/25/1957							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF March 1, 57		NAME OF CEMETERY OR CREMATORIUM Laffayette Memorial Park			
24. REC'D BY REGISTRAR John E. Henderson		REGISTER'S SIGNATURE J. E. Henderson		25. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home			
DATE 3/6/1957				ADDRESS Annapolis, Md.			

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1957

RECORDED BY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

BURIAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon paper. It should be filed with the funeral director.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

BURIAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon paper. It should be filed with the funeral director.

VS A15 (4)
 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1361

CERTIFICATE OF DEATH

01385
 21

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewater		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital						e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First LULA	Middle LEE	Last DOLAN	4. DATE OF DEATH Month February	Day 20	Year 1957
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 31, 1894	9. AGE (In years last birthday) 62 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Ky		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ben Gregory				14. MOTHER'S MAIDEN NAME Dora Spradlin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> --- ---		16. SOCIAL SECURITY NO. --- ---		17. INFORMANT Mr. Jack Dolan - Husband - same as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident						INTERVAL BETWEEN ONSET AND DEATH 2 hours	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Arteriosclerosis		(b)				UNKNOWN	
DUE TO Arteriosclerosis		DUE TO Arteriosclerosis					
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month March	Day 19	Year 1956	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Annapolis	(County) (State)
21. I certify that I attended the deceased from MARCH, 1956, to FEB, 1957 , that I last saw the deceased alive on 20 FEB, 1957 , and that death occurred at 7:45 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Edward S. Beck		M.D.		ADDRESS (Street, city or town, state) 41 Southgate Ave. Annapolis, Md.		DATE SIGNED 3/27/57	
PHYSICIAN'S NAME (Type) Edward S. Beck MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-23-57	22c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Cemetery		22d. LOCATION (City, town, or county) Annapolis, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME		ADDRESS Annapolis, Md.		24a. REC'D BY REGISTRAR TEB 20 1957	24b. REGISTRAR'S SIGNATURE John J. Lynch	DATE	

41/50

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01386

1470 CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY A.A.C.O.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena		c. LENGTH OF STAY IN b 20 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Laurel Acres, Pasadena Md.		e. STREET ADDRESS Laurel Acres, Pasadena Md.	
3. NAME OF DECEASED (Type or print) Shepherd		First Drain Jr.	Last Feb. 7, 1957
4. DATE OF DEATH Feb. 7, 1957	Month Feb.	Day 7	Year 1957
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED NEVER MARRIED WIDOWED DIVORCED	8. DATE OF BIRTH March 31, 1906
9. AGE (In years last birthday) 50	10. KIND OF BUSINESS OR INDUSTRY Own	11. BIRTHPLACE (State or foreign country) Md.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Dr. Shepherd Drain		14. MOTHER'S MAIDEN NAME Maud	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
		17. INFORMANT Mrs Dorothy Drain, Laurel Acres, Pasadena	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 161X DUE TO Carcinoma lunges		INTERVAL BETWEEN ONSET AND DEATH 18 months	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 6, 1957, to Feb. 7, 1957, that I last saw the deceased alive on Feb. 6, 1957, and that death occurred at M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) RIVIERA BEACH, MD. DATE SIGNED 2/8/57			
ACTUAL SIGNATURE J. BRADY SMITH PHYSICIAN'S NAME (Type) J. BRADY SMITH		22. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF Feb. 9/57		22c. NAME OF CEMETERY OR CREMATORIUM Druid Ridge	
23. FUNERAL DIRECTOR'S SIGNATURE Harry H. Witzke, 4101 Edmondson Ave.		22d. LOCATION (City, town, or county) Pikesville Md.	
		24a. REC'D BY REGISTRAR FBI 1150 DATE	
		24b. REGISTRAR'S SIGNATURE L.J. Deale	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO BURIAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 the registrar may bury, cremate, removal, in an event within 72 hours after death.

BUREAU X. 8

FEB 11 1957

K-52-V-EU

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01387

1401

CERTIFICATE OF DEATH

Reg. Dist. No.

34

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY AA		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Margate, Glen Burnie		c. LENGTH OF STAY IN lb 2 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Margate, Glen Burnie		d. STREET ADDRESS Leymar Road		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Leymar Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Max		First	Middle	Lost	4. DATE OF DEATH Eschenbach	Month	Day	Year
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 24, 1889	9. AGE (In years lost birthday) yrs. 67	10. IF UNDER 1 YEAR Months 516	11. IF UNDER 24 HRS Days First Ave SW	Hours Glen Burnie, Md.	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Storekeeper		10b. KIND OF BUSINESS OR INDUSTRY Own Store		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Oscar Albert Eschenbach		14. MOTHER'S MAIDEN NAME Lena Ludwig						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO none		17. INFORMANT William Eschenbach, Address				
				516 First Ave SW				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cardio hypertensive vascular diseases						
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. <i>Blind</i>		INTERVAL BETWEEN ONSET AND DEATH 2 years						
(b) DUE TO <i>Blind</i>								
(c) DUE TO <i>Blind</i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) Glen Burnie, Md.		(State)
21. I certify that I attended the deceased from June 1955 , to Feb. 18 1957 , that I last saw the deceased alive on 2/18/57 , and that death occurred at 10 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Glen Burnie, Md.						
DATE SIGNED								
MEDICAL CERTIFICATION SIGNATURE <i>Gustave H. Faubert</i>		GUSTAVE H. FAUBERT, M.D.						
PHYSICIAN'S NAME (Type) Gustave H. Faubert, M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 21, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill		22d. LOCATION (City, town, or county) (State) Baltimore 25, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE <i>James A. Kirkley</i>		ADDRESS Hopping and Kirkley, Glen Burnie, Md.		24a. REC'D BY REGISTRAR 321 1957		24b. REGISTRAR'S SIGNATURE <i>L.J. DeAlley</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: This death certificate is issued within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Please do not file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

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23

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01388

1362

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO BURIAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Part 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hanover</i>	c. LENGTH OF STAY IN 1b <i>1 month</i>	b. COUNTY <i>Anne Arundel</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Anne Arundel General</i>	d. STREET ADDRESS <i>22 Monroe Court</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <i>James</i>	First <i>James</i>	Middle <i>-</i>	Last <i>Emmanuel</i>
4. DATE OF DEATH <i>Feb. 4 1952</i>	Month <i>Feb.</i>	Day <i>4</i>	Year <i>1952</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>19</i>
9. AGE (In years last birthday) <i>19</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. AGE (In years last birthday) yrs. <i>19</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Bartender</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Tavern</i>	11. BIRTHPLACE (State or foreign country) <i>Turkey</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Not Known</i>	14. MOTHER'S MAIDEN NAME <i>Not Known</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	17. INFORMANT <i>Malama Emanuel</i>	Address <i>#(2)</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchogenic carcinoma & cerebral metastasis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) _____ DUE TO (c) _____			
INTERVAL BETWEEN ONSET AND DEATH <i>18 mos.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Hour a. m. p. m.	Month <i>Feb.</i>	Day <i>4</i>	Year <i>1952</i>
20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>None</i>	20f. (City or town) <i>Anne Arundel</i>	(County) <i>Md.</i>
21. I certify that I attended the deceased from <i>Jan.</i> , 19 <i>52</i> , to <i>Feb. 4</i> , 19 <i>52</i> , that I last saw the deceased alive on <i>Feb 4</i> , 19 <i>52</i> , and that death occurred at <i>295</i> M. From the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>John L. Hedeman</i>			
ACTUAL SIGNATURE <i>John L. Hedeman</i>		DATE SIGNED <i>2/4/52</i>	
PHYSICIAN'S NAME (Type) <i>Dr. John L. Hedeman</i>		M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>2-6-1952</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>St. Margaret's</i>	22d. LOCATION (City, town, or county) <i>Anne Arundel</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John H. Taylor & Sons (Annapolis, Md.)</i>		ADDRESS <i>90 Cathedral St., Annapolis, Md.</i>	24a. REC'D BY REGISTRAR DATE <i>2/5/52</i>
		24b. REGISTRAR'S SIGNATURE <i>J. Brown</i>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01388

1402

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Baltimore City		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN lb 20 yrs. 11 mos. 6 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		d. STREET ADDRESS 484 Prestman St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Thomas		First	Middle	Last	4. DATE OF DEATH 2	Month	Day	Year 10 19 57
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		B. DATE OF BIRTH 1895?	9. AGE (In years less birthday) 62 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Launderer		10b. KIND OF BUSINESS OR INDUSTRY Laundry		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U. S.		
13. FATHER'S NAME Thomas Giles		14. MOTHER'S MAIDEN NAME Sallie Giles						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Hospital Records		Address State Hospital Crownsville, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X		DUE TO Cerebral Thrombosis				INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO Hypertensive cardiovascular Disease						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Tabo-paresis with Charcot's joint						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 2/8 , 19 57 , to 2/10 , 19 57 , that I last saw the deceased alive on 2/8 , 19 57 , and that death occurred at 11:15 p.m. from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>Lionel McHenry Mapp.</i>		M.D.		ADDRESS (Street, city or town, state) Crownsville, Md.		DATE SIGNED 2/11/57		
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-18-57		22c. NAME OF CEMETERY OR CREMATORY Bladensburg, Md. Necrop.		22d. LOCATION (City, town, or county) Baltimore, Md.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE William Peacock - Annapolis, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE 19 1957		24b. REGISTRAR'S SIGNATURE <i>J. M. Joyce</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Please do not file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
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may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
it should be detached for use as the burial-transit Permit. Then please remove carbon paper. Part 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01390

1403

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN lb 19 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City		d. STREET ADDRESS 1625 Madison Avenue			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS 1625 Madison Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) John		First Hampton Middle Goldman		4. DATE OF DEATH 2		Month	Day	Year	
5. SEX Male		6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Not given		9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S.			
13. FATHER'S NAME William Henry		14. MOTHER'S MAIDEN NAME Not given							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records		Address State Hospital Crownsville, Md.			
18. CAUSE OF DEATH: [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia and Senility 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Cardiovascular-renal Disease 2628 (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Diabetes mellitus, mild and malnutrition						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Crownsville, Md.	(County)	(State)		
21. I certify that I attended the deceased from 1/22 , 19 57 to 2/10 , 19 57 , that I last saw the deceased alive on 2/8 , 19 57 , and that death occurred at 8:38 P.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state) Crownsville, Md.		DATE SIGNED 2/11/57			
22a. PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/15/57		22c. NAME OF CEMETERY OR CREMATORIUM Art. Barber		22d. LOCATION (City, town, or county) Baltimore Md.			
23. FUNERAL DIRECTOR'S SIGNATURE W. M. J. G. S. Blakely		ADDRESS 1808 Monroe St.		24a. REC'D BY REGISTRAR DATE 2-13-57		24b. REGISTRAR'S SIGNATURE Z. M. Jayas			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1363

CERTIFICATE OF DEATH

01391

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Part 1 and 2 should be detached for use as the burial-trust permit. Then please remove carbon papers. Part 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b 10	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1904 Brew St. - Annapolis, Md.</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	
d. STREET ADDRESS <i>1904 Brew St.</i>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Charlie Grandison</i>		First <i>Charlie</i>	Middle <i>Grandison, Jr.</i>
4. SEX <i>Male</i>		5. COLOR OF HAIR <i>Col.</i>	
6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		7. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>5-28-1900</i>		9. AGE (in years last birthday) <i>56 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Naval Acad. Water Proof, La.</i>	
11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. MOTHER'S NAME <i>Mellie Grandison</i>		14. MOTHER'S MAIDEN NAME <i>Connie E. Grandison</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input checked="" type="checkbox"/> (Type, no, or unknown) <i>yes</i>		16. SOCIAL SECURITY NO. <i>119-16-0773</i>	
17. INFORMANT <i>Coronary Circumstances</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i>		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>10-24-56</i> , 19, to <i>3-28-57</i> , 19, that I last saw the deceased alive on <i>2-22-57</i> , 19, and that death occurred at <i>122 Brew St.</i> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>G.T. Allen</i>		M.D. ADDRESS (Street, city or town, state) <i>62 Locality St. Annapolis, Md.</i>	
PHYSICIAN'S NAME (Type) <i>G.T. Allen</i>		DATE SIGNED <i>3-28-57</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3-24-57</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Brewer Dell</i>		22d. LOCATION (City, town, or county) (State) <i>Annapolis, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Lewis - Annapolis, Md.</i>		24. REC'D BY REGISTRAR DATE <i>Mar 4 1957</i>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <i>W.L. Lewis</i>	

BUREAU V. S.

MAR 4 1967

REGISTRATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1364

CERTIFICATE OF DEATH

01392

Reg. Dist. 21

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel Maryland</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <i>Maryland A.A.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	c. LENGTH OF STAY IN 1b <i>18 College Ave.</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	d. STREET ADDRESS <i>18 College Ave.</i>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>18 College Ave.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Hannah</i>	First	Middle	Last
4. DATE OF DEATH <i>2 16 1957</i>	Month	Day	Year
5. SEX <i>Female</i>	6. COLOR OF HAIR <i>Black</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-5-1877</i>
9. AGE (in years less birthday) <i>80 yrs</i>		10. IF UNDER 1 YEAR Months <i>2</i>	11. IF UNDER 24 HRS Days <i>16</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Nestleiner, Md.</i>	
11. BIRTHPLACE (State or foreign country) <i>Preston, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Gross</i>		14. MOTHER'S MAIDEN NAME <i>Louise Gross</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>10-100000000-00</i>	
17. INFORMANT <i>Helen Rawlings - Annapolis, Md.</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>443X</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) (c)		Cirrhosis of liver Cardiovascular disease Gastric trouble	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>18 College Ave., Annapolis, Md.</i>		(County) <i>Anne Arundel County</i> (State) <i>Md.</i>	
21. I certify that I attended the deceased from <i>Feb 21, 1957</i> to <i>Feb 16, 1957</i> , that I last saw the deceased alive on <i>Feb 16, 1957</i> , and that death occurred at <i>11:30 AM</i> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Annapolis, Md.</i>	
ACTUAL SIGNATURE <i>R. Richardson</i>		DATE SIGNED <i>2/18/57</i>	
PHYSICIAN'S NAME (Type) <i>William Keese, Jr.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		22b. DATE THEREOF <i>2-20-57</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Brewer Hill</i>		22d. LOCATION (City, town, or county) <i>Annapolis, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Keese, Jr.</i>		24a. REC'D BY REGISTRAR DATE <i>Mar 1 1957</i>	
ADDRESS <i>Annapolis, Md.</i>		24b. REGISTRAR'S SIGNATURE <i>J. Beale</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

MR

REG'D U.S. PAT. OFF.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 11, 13, 14, 15, 16, 17, 2-25-57 et

01393

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN lb 1yr. 5mos. 20 days Baltimore City	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		e. STREET ADDRESS 1340 Stockton St.	
3. NAME OF DECEASED (Type or print) First Veretta		4. DATE OF DEATH Last Harvey Month 2 Day 13 Year 1957	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Unk.	8. DATE OF BIRTH Not given
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) North Carolina
13. FATHER'S NAME Alex Pratt		14. MOTHER'S MAIDEN NAME Betsy Pratt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Insufficiency			
422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) Senility			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Dehydration, Malnutrition, Decubitus Ulcers			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/25 , 19 56 , to 2/13 , 19 57 , that I last saw the deceased alive on 2/13 , 19 57 , and that death occurred at 4:40 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Lionel McHenry Mapp M.D. Crownsville, Md. 2/14/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-20-57	
22c. NAME OF CEMETERY OR CREMATORIUM Mount Zion		22d. LOCATION (City, town, or county) (State) Hanover County	
23. FUNERAL DIRECTOR'S SIGNATURE Charles Alexander		ADDRESS #2700 Edmondson	
		24a. REC'D BY REGISTRAR DATE 2-18-57	
		24b. REGISTRAR'S SIGNATURE Z. M. Joyce	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Part 3 should be detached for use as the burial-trust permit. Then please remove carbon paper. Part 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this copy has been executed by the attending physician and completed in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transcript.

V5 A15C 1-55 10W

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01394

1956 CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY	MARYLAND			STATE	COUNTY		
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)			CITY (If outside corporate limits, write RURAL and give nearest town)	TOWN		
TOWN	FORT GEORGE MEADE, 13 DAYS			X	N. LINTHICUM		
HOSPITAL OR INSTITUTION OR STREET ADDRESS	U.S. ARMY HOSPITAL			STREET ADDRESS	(If rural give location)		
3. NAME OF DECEASED (First) (Middle) (Last)	BLANCA IRIS Hernandez			4. DATE OF DEATH	(Month)	(Day)	(Year)
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
FEMALE	CHICASIAN		FEB 6, 1957	— yrs.	Months	Days	Hours Min.
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
				MARYLAND		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
ENRIQUE HERNANDEZ				MARIA MILAGROS BREBAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.			
(If Yes, give war or dates of service)				17. INFORMANT & ADDRESS			
				307 REGNEY CIRCLE N. LINTHICUM, MD			
18. MEDICAL CERTIFICATION				FATHER, ENRIQUE HERNANDEZ			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Prematurity							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, (B) Possibly after respiration immature							
GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
INTERVAL BETWEEN ONSET AND DEATH							
13 DAYS							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19e. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION							
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 6 FEB 1957, to 17 FEB 1957, that I last saw the deceased alive on 19 FEB 1957, and that death occurred at 2:08PM, from the causes and on the date stated above. SIGNATURE James S. White, M.D. ADDRESS (Street, city, town, state) DATE SIGNED							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORIUM		LOCATION (City, town, or county) (State)	
Social		2-21-57		BALTIMORE NATIONAL		BALTIMORE, MD	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
		L.W. SAVIOR, MSC		WILLIAM COOK JR.		1817 ST. PAUL ST.	
DATE FEB 19, 1957							

BUERZAU V. 8
13. 6. 1957
DIESELIVE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in Item 18, Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the remains.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 1407 DM 2, Film GP10, 2/8/57 bh										Reg. Dist. No. 01395							
1. PLACE OF DEATH a. COUNTY Anne Arundel					MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linthicum Heights					c. LENGTH OF STAY IN lb 4 months							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Hanover Nursery Roads										2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Same							
										b. COUNTY Same							
										c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Same							
										d. STREET ADDRESS Same							
										e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First Million Evelyn Hinkle	Middle	Last	4. DATE OF DEATH	Month February 1st.	Day	Year 19 57									
5. SEX		6. COLOR OR RACE F White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/14/26	9. AGE (In years last birthday) 790 yrs.	IF UNDER 1 YEAR Months 2		IF UNDER 24 HRS. Days 30								
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Own Home			11. BIRTHPLACE (State or foreign country) Virginia			12. CITIZEN OF WHAT COUNTRY? U.S.A.								
13. FATHER'S NAME Million Osborn Woodston					14. MOTHER'S MAIDEN NAME Evelynn Dora Philipps												
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. None			17. INFORMANT Mr. Charles Hinkle, same as 2											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Aspiration of vomitus due to acute alcoholism										INTERVAL BETWEEN ONSET AND DEATH							
322.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)																	
DUE TO (c)																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 														
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town)		(County)		(State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/>																	
ACTUAL SIGNATURE Russell S. Fisher		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>								DATE SIGNED 2-2-57							
EXAMINER'S NAME (Type) Russell S. Fisher																	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/4/57		22c. NAME OF CEMETERY OR CREMATORIUM Glen Haven Memorial			22d. LOCATION (City, town, or county) Glen Burnie, Md.										
23. FUNERAL DIRECTOR'S SIGNATURE Jamey E. Lubley		ADDRESS Hopping and Kirkley, Glen Burnie, Md.		24a. REC'D BY REGISTRAR FEB 5 1957			24b. REGISTRAR'S SIGNATURE A. H. Hedricks										

BUREAU V. S.

FEB 3

KELCEY V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01396

Name: G211 2-20-57 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH

a. COUNTY Anne Arundel

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL
and give nearest town)

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Curtis Creek

3. NAME OF
DECEASED
(Type or print)Alfred Middle
Albert E.

ALFRED GOTTFRIED HORNEY

Horney

625 Grantley

Tow

DATE
OF
DEATH

Month

Day

Year

Feb.

8,

1957

4. SEX

Male

6. COLOR OR RACE White

WIDOWED

DIVORCED

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH JAY 24/1903

9. AGE (in years
at birthday) 98 5M

IF UNDER 1 YEAR

Months

IF UNDER 24 HRS.

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

SALTSMAN/KRANZ-WILSMUSIS CO

GERMANY

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

FRERICKA HORNIG

14. MOTHER'S MAIDEN NAME

SELMA HEYER

Address

212-163415 MRS E HORNIG 625 GRANTLEY ST

15. WAS DECEASED EVER IN U. S. ARMED FORCES?

(Yes, no, or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

212-163415 MRS E HORNIG 625 GRANTLEY ST

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Drowning

975X

DUE TO

Conditions, if any, which

gave rise to immediate cause

(a), stating the underlying

cause lost.

(b)

DUE TO

(c)

INTERVAL BETWEEN
ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS

PRIMARY or CONTRIBUTING

CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

Drowned self

20c. TIME OF INJURY Month, Day, Year

Hour a. m.

p. m.

19

20d. INJURY OCCURRED

White

Not white

of work of work

20e. PLACE OF INJURY (Home, farm,

factory, street, office bldg., etc.)

Creek

20f. (City or town)

Anne Arundel

(County)

Md.

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and find thatdeath resulted from: Natural causes Accident Suicide Homicide Undetermined cause

22. ACTUAL SIGNATURE

William V. Lovitt

Jr., M.D.

23. EXAMINER'S NAME (Type)

24. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

25. DATE SIGNED

2/11/57

26. FURNAL CREMATION, DORMANT

27. DATE THEREOF

28. NAME OF CEMETERY OR CREMATORIAL

LORRAINE PARK

29. LOCATION (City, town, or county)

WOODLAWN

MD

20. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

GEO. A. LEIMBACH

525 N LYNCHBURG

ST

21. REC'D BY REGISTRAR

DATE 2-13-57

22. REGISTRAR'S SIGNATURE

L. J. Schellap

ST

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

V.S. ATMS(E)
SM 9/55

B A T

IP

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01397

1365

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN lb <i>205 Cherry Grove Ave</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>205 Cherry Grove Ave</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	
f. STREET ADDRESS <i>205 Cherry Grove Ave</i>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Mary W. Hurlock</i>		First	Middle
		Last	
4. DATE OF DEATH <i>2 - 9 - 1957</i>		Month	Day
		Year	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
		8. DATE OF BIRTH <i>10-6-1872</i>	
9. AGE (In years lost, birthday) <i>84 yrs</i>		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	10c. BIRTHPLACE (State or foreign country) <i>Calvert Co Md.</i>
11. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>James H. Jones</i>		14. MOTHER'S MAIDEN NAME <i>Mary E. Wood</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>000-00-0000</i>	
17. INFORMANT <i>Mrs Leo D. Miller</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerosis generalized</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <i>Arteriosclerosis generalized</i> DUE TO (c) <i>Arthritis</i> INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> off work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Jan 10, 1948</i> to <i>Feb 9, 1957</i> , that I last saw the deceased alive on <i>Feb 9, 1957</i> , and that death occurred at <i>105 M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>James R. Martin</i> PHYSICIAN'S NAME (Type) <i>JAMES R. MARTIN</i>		ADDRESS (Street, city or town, state) <i>6 Shaw St. Annapolis, MD.</i> DATE SIGNED <i>2/11/57</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>2-12-57</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Bluff</i>		22d. LOCATION (City, town, or county) <i>Annapolis</i> (State) <i>MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons Annapolis Md</i>		24a. REC'D BY REGISTRAR & 24b. REGISTRAR'S SIGNATURE <i>John M. Taylor Sons Annapolis Md</i>	

Y A S

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GRAN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Part 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Part 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01398

CERTIFICATE OF DEATH

Reg. Dist. No. 78

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore 1500 E 35th St</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Elgewater</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Towson State Hospital Route 2</i>		d. STREET ADDRESS <i>None</i>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>JOHN WESLEY KAES</i>		First <i>JOHN</i>	Middle <i>WESLEY</i>
Last <i>KAES</i>		4. DATE OF DEATH <i>FEB 3 1957</i>	Month <i>FEB</i>
Day <i>3</i>		Year <i>1957</i>	
5. SEX <i>M</i>		6. COLOR OR RACE <i>NEGRO</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>5-6-1892</i>		9. AGE (In years lost birthday) <i>65 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>FARM LABOUR</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>FARMER</i>	
11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John</i>		14. MOTHER'S MAIDEN NAME <i>John</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Dorothy Graces Elgewater Md.</i>		Address <i>John</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>422.1</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Cardio vascular disease</i>	
DUE TO <i>Arteriosclerosis</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>None</i>			
DUE TO (c) <i>None</i>			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>None</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>None</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) <i>None</i>
21. I certify that I attended the deceased from <i>12/18</i> , 1956, to <i>2/3</i> , 1957, that I last saw the deceased alive on <i>2/3</i> , 1957, and that death occurred at <i>5:00 A.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>John G. Hardy</i> PHYSICIAN'S NAME (Type) <i>John G. Hardy</i>		ADDRESS (Street, city or town, state) <i>Silver Spring Md.</i> DATE SIGNED <i>None</i>	
22a. BURIALS CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>2-6-57</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Chesapeake Chapel</i>
22d. LOCATION (City, town, or county) <i>Owensville Md.</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Mr. Bill Reese Wm. Reese II</i>		24a. REC'D BY REGISTRAR <i>Feb 4 1957</i>	24b. REGISTRAR'S SIGNATURE <i>E. M. Joyce</i>

RECEIVED
FEB 4 1968
PURVIS V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01399

1366

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Part 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Part 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Anne Arundel</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis Md</i>		c. LENGTH OF STAY IN 1b <i></i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		d. STREET ADDRESS <i>141-LARKINS</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>H-LARKINS</i>				d. STREET ADDRESS <i>141-LARKINS</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>WILLIAM</i>		First	Middle	Lost	4. DATE OF DEATH <i>Johnson</i>	Month	Day	Year
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>68</i>	9. AGE (In years last birthday) 68 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>		11. BIRTHPLACE (State or foreign country) <i>Davidsonville Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>CHARLES JOHNSON</i>				14. MOTHER'S MAIDEN NAME <i>Matilda SPENCER</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i></i>		17. INFORMANT <i>MASSIE JOHNSON 141-LARKINS ST.</i>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>443X</i>		DUE TO <i>Arterio sclerotic hyalinized</i>				INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b)		DUE TO <i>Cardiovascular disease Grade III</i>						
(c)								
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, 20f. (City or town) factory, street, office bldg., etc.) <i>40-day old</i>		(County)		(State)
21. I certify that I attended the deceased from <i>Jan 18, 1957</i> to <i>Feb 18, 1957</i> , that I last saw the deceased alive on <i>Feb 18, 1957</i> , and that death occurred at <i>40-day old</i> M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Dr. R. L. Johnson</i>		ADDRESS (Street, city or town, state) <i>Annapolis, Md.</i>						
PHYSICIAN'S NAME (Type) <i>John J. French</i>		DATE SIGNED <i>2/20/57</i>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Syrup</i>		22b. DATE THEREOF <i>2/20/57</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>BREW Hill</i>		22d. LOCATION (City, town, or county) <i>ANNAPOLIS</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ethel Shum, 43 with wife</i>		ADDRESS <i>141-LARKINS</i>		24a. REC'D BY REGISTRAR DATE <i>7/20/57</i>		24b. REGISTRAR'S SIGNATURE <i>John J. French</i>		

RECEIVED
BUREAU V. S.

FEB 9 1 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01400

1367

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	c. LENGTH OF STAY IN 1b <i>1 month</i>	b. COUNTY <i>Anne Arundel</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wardour</i>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Anne Arundel General</i>	d. STREET ADDRESS <i>113 Wardour Drive</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <i>Raymond Henry Lacey</i>	First <i>R</i>	Middle <i>aymond</i>	Last <i>Lacey</i>
4. DATE OF DEATH <i>February 8 1957</i>	Month <i>February</i>	Day <i>8</i>	Year <i>1957</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>January 27 1876</i>
9. AGE (in years (last birthday)) <i>81</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Professor</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Education</i>	11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Henry W. Lacey</i>	14. MOTHER'S MAIDEN NAME <i>Clive Durand</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>160</i>	17. INFORMANT <i>Douglas Lacey</i>	Address <i># 2</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Jobar pneumonia</i>			
DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Cerebral Vascular accident</i>			
DUE TO (c) <i>Generalized arteriosclerosis</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. / p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Frank McSlempy</i>	ADDRESS (Street, city or town, state) <i>63 College Ave</i>		DATE SIGNED <i>2/18/57</i>
PHYSICIAN'S NAME (Type) <i>Frank McSlempy</i>	M.D. <i>Annapolis, Md</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	22b. DATE THEREOF <i>2-11-57</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Taylor Sins Annapolis Md</i>	22d. LOCATION (City, town, or county) <i>Taylor Sins</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sins Annapolis Md</i>	ADDRESS <i>John M. Taylor Sins Annapolis Md</i>	24a. REC'D BY REGISTRAR DATE <i>- U. Driscoll</i>	24b. REGISTRAR'S SIGNATURE <i>U. Driscoll</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as a burial transit permit. Then please remove carbon paper, and in any event within 72 hours after death, the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please cut the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be worded to the Ch. of Medical Examiner's Office along with form PM3. Page 5 may be retained for our files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with me. File prior to burial or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										01401														
										Reg. Dist. No.														
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN lb					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pines on the Severn</u> d. STREET ADDRESS <u>X</u>																			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>J. A. General Hospital</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
3. NAME OF DECEASED (Type or print) <u>Scott</u>		First	Middle	Last	4. DATE OF DEATH <u>24. gafferty</u> Month <u>2</u> Day <u>23</u> Year <u>1957</u>		5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u>			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 25 1957</u> 9. AGE (In years last birthday) <u>4 weeks</u>		10. IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		11. IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>								
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>					11. BIRTHPLACE (State or foreign country) <u>Annapolis Md</u>					12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>									
13. FATHER'S NAME <u>Frank H. Lafferty</u>					14. MOTHER'S MAIDEN NAME <u>Jean Whitlock</u>					15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>					16. SOCIAL SECURITY NO. <u>7</u> 17. INFORMANT <u>Same as 13 - 2</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH														
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>71</u> (b) DUE TO (c)										Died Sudden														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>														
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <u>Annapolis</u> (County) <u>Md</u> (State) <u></u>				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>										DATE SIGNED <u>2/13/57</u>														
ACTUAL SIGNATURE <u>John B. Lafferty</u> EXAMINER'S NAME (Type) <u>E. Linhardt</u>										M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>														
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-23-57</u>			22c. NAME OF CEMETERY OR CREMATORIUM <u>Hillcrest Memorial</u>			22d. LOCATION (City, town, or county) <u>Annapolis</u> (State) <u>Md</u>																
23. FUNERAL/DIRECTOR'S SIGNATURE <u>John M. Taylor Sons Annapolis Md</u>					ADDRESS <u>100 Church</u>					24a. REC'D BY REGISTRAR <u>John M. Taylor Sons Annapolis Md</u> DATE <u>Feb 25 1957</u>					b. REGISTRAR'S SIGNATURE									

SHAFAU V. S.

TB - 1357

RECEIVED

1419

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01402

Reg. Dist. No. 27

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY A.A.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linthicum Heights		c. LENGTH OF STAY IN 1b Few seconds		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Meade			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 170				d. STREET ADDRESS Home address: 424 Swale Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
e. DATE OF DEATH February 16th, 1957				f. MONTH Month Day Year			
3. NAME OF DECEASED (Type or print)	First John Linwood	Middle Lewis	Last	4. DATE OF DEATH	Month	Day	Year
5. SEX M.	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 9/4/27	9. AGE (In years less birthday) 29 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during post of working life, even if retired) Soldier in the U.S. Army			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Nattaway Co., VA		
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John B. Lewis				14. MOTHER'S MAIDEN NAME Gladys May			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) In the army at present				16. SOCIAL SECURITY NO. 228-28-5527		17. INFORMANT Fort Meade Records.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture of skull				INTERVAL BETWEEN ONSET AND DEATH Sudden			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Sudden							
(b)							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Hour 6.15 a.m. 2/16/57 19		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Automobile skidded on route 170					
20c. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 170		20f. (City or town) Linthicum Heights, A.A. Md. (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Gustave H. Faubert, M.D.				DATE SIGNED 2/16/57			
NAME (Type) Gustave H. Faubert, M.D.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 20 Feb 57		22c. NAME OF CEMETERY OR CREMATORIUM LITTLE (FA. LILY) CEMETARY		22d. LOCATION (City, town or County) CITY OF BALTIMORE, VIRGINIA (State) XXXXXXXXXXXXXX	
23. FUNERAL DIRECTOR SIGNATURE William S. R. Lai				ADDRESS 802 Madison Av., Baltimore, Md.			
				24a. REC'D BY REGISTRAR DATE 19 Feb 57		24b. REGISTRAR'S SIGNATURE L. SALOMON, 1/Lt. SC	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for our files.
 BURIAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED
FEB 21 1957

BUREAU V. 2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
1910 CERTIFICATE OF DEATH

014034

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		
Anne Arundel MARYLAND			Maryland b. COUNTY Bel Air City		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
Glen Burnie	4 yrs		Baltimore		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	e. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
118 Wilson Blv. S.W.	1432 Carroll St				
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month Day Year
MICHAEL			LITZ	FEB. 12th	1957
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR IF UNDER 24 HRS
M	W		July 27 1918	7 yrs.	Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Furniture Finisher	Furniture		Bel Air, Md.		yes USA
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME				
unknown	unknown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO.		17. INFORMANT		Address
	111-27-1234		Mrs Mary Riley (daughter)		118 Wilson Blv S.W. Glen Burnie
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)					
400.0	DUE TO		acute myocardial infarction		
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost.	(b)		arteriosclerotic Heart disease		
(c)					4 yrs
INTERVAL BETWEEN ONSET AND DEATH 1 day					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
Previous myocardial attack 6 mos ago.					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) no injury			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <input checked="" type="checkbox"/> 19 p. m. <input type="checkbox"/>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19_____, to 12 Feb 1957, that I last saw the deceased alive on _____, 19_____, and that death occurred at 2:15 P.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>H.F. Manuzak</i>			ADDRESS (Street, city or town, state) <i>901 Edgely Rd, Glen Burnie</i> DATE SIGNED <i>12 Feb 57</i>		
PHYSICIAN'S NAME (Type) <i>H.F. MANUZAK</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Feb 13, 1957</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Glen Haven</i>		22d. LOCATION (City, town, or county) <i>Glen Burnie</i> (State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>R. Clayton</i>		ADDRESS <i>Glen Burnie, Md.</i>		24a. REC'D BY REGISTRAR <i>Feb 14, 1957</i>	24b. REGISTRAR'S SIGNATURE <i>L.D. Alba</i>

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

NOT TO NUMEROUS DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Note: Patient of Dr. J. C. Mac Donald. After surgery it was learned he was under care of Dr. John Burns. It was Dr. Mac who called when Dr. Burns was not at

V5 A15 (4)
15M 9/55

3. A.

150.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1411 CERTIFICATE OF DEATH

01404

Reg. Dist. No.

25

1. PLACE OF DEATH a. COUNTY		Anne Arundel Co. <i>Baltimore 666666666666</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
Brooklyn		50		Brooklyn					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 713 Church Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
f. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
<i>Mrs Antonia</i>				<i>Luban</i>	<i>Feb 24</i>			<i>1957</i>	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years lost birthday) 69 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.	
<i>Female</i>	<i>White</i>		<i>April , 1887</i>						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?
<i>Housewife</i>						<i>Poland</i>			<i>USA</i>
13. FATHER'S NAME <i>Joseph Kosnik</i>				14. MOTHER'S MAIDEN NAME <i>Eva Pryztulska</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO.		17. INFORMANT <i>Family</i>			Address
									<i>Same</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Adeno Carcinoma of Colon</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>with metastases</i> DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH <i>2 years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. <i>19</i> p. m.		Month, Day, Year <i>Sept 9th, 1956</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>5301 Har</i>	20f. (City or town) <i>Brooklyn, Ld.</i>	(County)	(State)		
21. I certify that I attended the deceased from <i>Sept 9th, 1956</i> to <i>Feb 24, 1957</i> , that I last saw the deceased alive on <i>Feb 24th, 1957</i> , and that death occurred at <i>12:12 P.M.</i> from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) <i>5301 Har</i>									
DATE SIGNED <i>1/1/57</i>									
ACTUAL SIGNATURE <i>W.W. Conway</i>									
PHYSICIAN'S NAME (Type) <i>McGinnis</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>2/27/57</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Holy Cross</i>			22d. LOCATION (City, town, or county) <i>Brooklyn, Ld.</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>McCullough Funeral Homes</i>		ADDRESS <i>130 E. Fort Ave.</i>				24a. REC'D BY REGISTRAR <i>FEB 26 1957</i>	24b. REGISTRAR'S SIGNATURE <i>Ida Watson</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. A.
B-03305
E.C.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01405

1412

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>A.A.</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i>		b. COUNTY <i>A.A.</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Edgewater</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Edgewater</i>		d. STREET ADDRESS <i></i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print)		First <i>Winfield</i>	Middle <i>Scott</i>	Last <i>Lyons Sr.</i>	4. DATE OF DEATH Month <i>2</i> - Day <i>16</i> Year <i>1957</i>					
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>May 28-1880</i>	9. AGE (In years lost birthday) <i>76 yrs.</i>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i></i>	Days <i></i>	Hours <i></i>	Min. <i></i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farm Tobacco</i>		11. BIRTHPLACE (State or foreign country) <i>Westover Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				
13. FATHER'S NAME <i>William F. Lyons</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Peake</i>								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>- - - - -</i>		17. INFORMANT <i>Winfield S. Lyons Jr. Edgewater Md.</i>		Address				
18. CAUSE OF DEATH [Enter only one cause per line (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i>						INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs.</i>				
331a Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>Arteriosclerosis Generalized</i>						2 yrs.				
(c) DUE TO <i>Pulmonary Emphysema</i>						3 yrs.				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>		20f. (City or town) <i></i>		(County) <i></i>	(State) <i></i>	
21. I certify that I attended the deceased from <i>Feb. 17, 1950</i> to <i>Feb. 16, 1957</i> , that I last saw the deceased alive on <i>Feb. 16, 1957</i> , and that death occurred at <i>3:30 P.M.</i> from the causes and on the date stated above.								ADDRESS (Street, city or town, state) <i>6 SHAW ST.</i>		
ACTUAL SIGNATURE <i>James R. Martin</i>		M.D.						DATE SIGNED <i>2/17/57</i>		
PHYSICIAN'S NAME (Type) <i>JAMES R. MARTIN</i>								<i>ANNAPOLIS, MD</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>2-19-57</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>St. Marys</i>		22d. LOCATION (City, town, or county) <i>Annapolis Md.</i>		(State) <i></i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i>		ADDRESS <i>Annapolis Md.</i>		24a. REC'D BY REGISTRAR <i>John</i>		24b. REGISTRAR'S SIGNATURE <i>John</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Form 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FEB 04 1957

REGELIVEL

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18
1369 CERTIFICATE OF DEATH

01406

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Anne Arundel</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b <i>1 week</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		d. STREET ADDRESS <i>116 Charles St.</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Anne Arundel General</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First <i>Rosaria</i>	Middle <i></i>	Last <i>Maggio</i>	DATE OF DEATH <i>February 25 1957</i>	Month <i>February</i>	Day <i>25</i>	Year <i>1957</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 7th 1872</i>	9. AGE (In years last birthday) <i>84 yrs.</i>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i></i> Days <i></i> Hours <i></i> Min <i></i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	11. BIRTHPLACE (State or foreign country) <i>Italy</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>				
13. FATHER'S NAME <i>Feltonio Citrano</i>		14. MOTHER'S MAIDEN NAME <i>Agnese Miceli</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i></i>	17. INFORMANT <i>Anthony J. Maggio</i>	Address <i>#2</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Kidney</i>				INTERVAL BETWEEN ONSET AND DEATH <i>3 yrs.</i>				
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i></i>		(b) DUE TO <i></i>						
(c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Annapolis</i>	(County) <i>Anne Arundel</i>	(State) <i>Md.</i>		
21. I certify that I attended the deceased from <i>Oct. 1952</i> to <i>Feb. 25, 1952</i> , that I last saw the deceased alive on <i>Feb. 14, 1957</i> , and that death occurred at <i>2:15 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>James A. Martin</i>				ADDRESS (Street, city or town, state) <i>Annapolis, Md.</i>				
PHYSICIAN'S NAME (Type) <i>James A. Martin</i>		M.D.		DATE SIGNED <i>3/25/57</i>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>2-27-1957</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>St. Mary's</i>	22d. LOCATION (City, town, or county) <i>Annapolis</i>	(State) <i>Md.</i>				
23. FUNERAL DIRECTOR'S SIGNATURE <i>John W. Taylor & Sons Annapolis, Md.</i>	ADDRESS <i></i>	24c. REC'D BY REGISTRAR DATE <i>Feb 26 1957</i>	24d. REGISTERED MONITOR DATE <i>3/25/57</i>					

BUREAU V. 2

1057 23

SEARCHED INDEXED SERIALIZED FILED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1370

CERTIFICATE OF DEATH

Reg. Dist. No.

014021

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	c. LENGTH OF STAY IN 1b <i>Annapolis</i>	d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	e. STREET ADDRESS <i>408 Chester Ave.</i>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>A.C. General Hosp.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <i>Brenda Ann Makell</i>	First <i>Brenda</i>	Middle <i>Ann</i>	Last <i>Makell</i>						
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Col</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-1-56</i>	9. AGE (In years lost birthday) yrs. <i>2</i>	10. IF UNDER 1 YEAR Months <i>2</i>	11. IF UNDER 24 HRS. Days <i>26</i>	12. Month <i>2</i>	13. Day <i>26</i>	14. Year <i>1957</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY <i></i>		11. BIRTHPLACE (State or foreign country) <i>Washington D.C., U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY? <i></i>			
13. FATHER'S NAME <i>John Albert Makell Jr.</i>		14. MOTHER'S MAIDEN NAME <i>Betty E. Grayt</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i></i>			17. INFORMANT <i>John Albert Makell Jr. - Annapolis, Md.</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>193X</i>		DUE TO <i></i>		INTERVAL BETWEEN ONSET AND DEATH <i>7 days</i>		<i>pneumonia</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i></i>		(b) <i></i>		7 days		<i>cerebral anoxia</i>			
		DUE TO <i></i>		7 days		<i>heart failure</i>			
		(c) <i></i>							
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>heart failure</i>									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i></i>							
20c. TIME OF INJURY Hour a. m. p. m.	Month <i>19</i>	Day <i></i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>	20f. (City or town) <i></i>	(County) <i></i>	(State) <i></i>		
21. I certify that I attended the deceased from <i>Feb 17, 1957</i> to <i>Feb 25, 1957</i> that I last saw the deceased alive on <i>Feb 25, 1957</i> , and that death occurred at <i>midnight</i> , from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) <i>Annapolis, Maryland</i>									DATE SIGNED <i></i>
ACTUAL SIGNATURE <i>Neil H. Sims</i>									
PHYSICIAN'S NAME (Type) <i>Neil H. Sims.</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>3-1-57</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Annapolis Natl.</i>	22d. LOCATION (City, town, or county) <i>Annapolis, Md.</i>						
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Leeser - Annapolis, Md.</i>	ADDRESS <i></i>	24a. REC'D BY REGISTRAR <i></i>	24b. REGISTRAR'S SIGNATURE <i>J. J. Evans</i>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

READY

3
AVAIL

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

1371

CERTIFICATE OF DEATH

01408

Reg. Dist. No. " 21

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X/ Crownsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First FERRIS	Middle 	Last MC KNEW	4. DATE OF DEATH	Month FEBRUARY	Day 15	Year 19 57
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> January 3, 1940	9. AGE (In years last birthday) 17 yrs.	IF UNDER 1 YEAR Months 	IF UNDER 24 HRS Days 	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY High School (3rd year)		11. BIRTHPLACE (State or foreign country) Gotts, Station, Md.		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Roland W. McKnew		14. MOTHER'S MAIDEN NAME Ruth V. Downs					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-36-3510		17. INFORMANT Roland W. McKnew Father- same as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) O 3.1 <i>Staphylococcal septicemia</i>		DUE TO (b)		INTERVAL BETWEEN ONSET AND DEATH 48 hrs.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 		DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) 	
21. I certify that I attended the deceased from 2/14 , 19 57 , to 2/15 , 19 57 , that I last saw the deceased alive on 2/15 , 19 57 , and that death occurred at 8 AM , from the causes and on the date stated above. ACTUAL SIGNATURE <i>John H. Hedeman</i> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 2/12/57					
PHYSICIAN'S NAME (Type) John Hedeman		90 Cathedral Street, Annapolis, Md.					
22d. BURIAL, CREMATION, REMOVAL (Specify) Burial		22e. DATE THEREOF 2-19-57		22c. NAME OF CEMETERY OR CREMATORIUM Baldwin Memorial Cemetery Millersville, Maryland		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. J. Hopping</i>		ADDRESS ANNAPOLIS, MD.		24a. REC'D BY REGISTRAR D 19 1957		24b. REGISTRAR'S SIGNATURE <i>W. J. Preach</i>	

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BALTIMORE

11/11/1981

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01409

1372

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL		c. LENGTH OF STAY IN 1b 1 yr.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis, Maryland					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. NAVAL HOSPITAL, ANNAPOLIS, MD.		d. STREET ADDRESS 107 Severn Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Baby Boy		First Baby	Middle McKOWN	Last McKOWN	4. DATE OF DEATH February 21 1957	Month February	Day 21	Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-21-57	9. AGE (In years lost birthday) yrs. 6	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME John Elliott McKOWN		14. MOTHER'S MAIDEN NAME Alice Lenore LUCAS							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. — — —		17. INFORMANT U.S. NAVAL HOSPITAL, ANNAPOLIS, MD.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (b) Prematurity with Immaturity DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the under- lying cause first. 776 X (b) DUE TO (c)									
INTERVAL BETWEEN ONSET AND DEATH									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) U.S. Naval Academy, Annapolis, Md.		(County) Anne Arundel	
21. I certify that I attended the deceased from 21 FEB 1957 , to 21 FEB 1957 , that I last saw the deceased alive on 21 FEB 1957 , and that death occurred at 10:05 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Academy, Annapolis, Md. DATE SIGNED 21 FEB 1957									
ACTUAL SIGNATURE Richard D. Sheehan		PHYSICIAN'S NAME (Type) RICHARD D. SHEEHAN LT MC USNR U.S. NAVAL HOSPITAL, ANNAPOLIS, MD.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 2-25-1957		22c. NAME OF CEMETERY OR CREMATORIUM U.S. Naval Academy, Annapolis, Md.		22d. LOCATION (City, town, or county) Anne Arundel		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor, Annapolis, Md.		ADDRESS 107 Severn Ave., Annapolis, Md.		24e. RECD BY REGISTRAR John M. Taylor, Annapolis, Md.		24f. REGISTRAR'S SIGNATURE John M. Taylor, Annapolis, Md.		DATE 2-25-1957	

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RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01410

1413

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Baltimore City		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN lb 1yr. 3mos. 16days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City 3Y 21-4				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		d. STREET ADDRESS 507 Laurens St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First Viola	Middle	Last Meads	4. DATE OF DEATH 2	Month 2	Day 4	Year 1957
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Not given		9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months 01	IF UNDER 24 HRS. Hours 01	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Not given		10b. KIND OF BUSINESS OR INDUSTRY - - -		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S.		
13. FATHER'S NAME Not given			14. MOTHER'S MAIDEN NAME Not given					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unit.		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Hospital Records		Crownsville State Hos. Address Crownsville, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Far advanced metastatic cancer of the breast 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypostatic Pneumonia, General wasting								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from 11/27, 1956, to 2/4, 1957, that I last saw the deceased alive on 11/31, 1956, and that death occurred at 10 p.m., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md.								
ACTUAL SIGNATURE <i>Lionel McHenry, M.D.</i>	DATE SIGNED 2/5/57							
PHYSICIAN'S NAME (Type)								
22a. BURIAL, CREMATION, REMOVAL (Specify) 2/9/57	22b. DATE THEREOF 2/9/57	22c. NAME OF CEMETERY OR CREMATORIUM Mt. Auburn		22d. LOCATION (City, town, or county) Baltimore, Md.		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles A. Rice 661 W. Barnes St.</i>		ADDRESS 2-13-57	24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE 25 M. Joyce			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Part 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Part 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01411
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1414

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE	
Anne Arundel MARYLAND		MD.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Severna Park. 25 yrs		Severna Park MD.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS	
Dividing Rd - Manhattan Beach		Dividing Rd.	
f. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First	Middle	Last
John			Mellor
4. SEX	5. COLOR OR RACE	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH
M.	W		MAY 4, 1880
8. AGE (In years last birthday) yrs.	9. IF UNDER 1 YEAR Months	10. IF UNDER 24 HRS. Days	11. Month
76			16
12. DAY Year	13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME	15. CITIZEN OF WHAT COUNTRY
16. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	17. KIND OF BUSINESS OR INDUSTRY	18. BIRTHPLACE (State or foreign country)	C.E.S.
Real Estate Broker	Real Estate	Sykesville	
19. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)	20. SOCIAL SECURITY NO.	21. INFORMANT	22. ADDRESS
No.		Mrs Rose Bachman Daughter	Same
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			
Myocardial INFarction			
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.			
(b) Generalized Arteriosclerosis			
DUE TO			
(c) Emphysema - Bronchiectasis.			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1955, 19, to 1957, 19, that I last saw the deceased alive on 2-15-57, 12, and that death occurred at 2:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE		ADDRESS (Street, city or town, state)	
PHYSICIAN'S NAME (Type)		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/18/57	
22c. NAME OF CEMETERY OR CREMATORIUM Springfield Cemetery		22d. LOCATION (City, town, or county) Sykesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm J. Ticknor Sons - North & Avenue		24a. REC'D BY REGISTRAR DATE Feb. 18, 1957	
		24b. REGISTRAR'S SIGNATURE L. J. DeAlley	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Part 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Part 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01412

1373

CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY <i>A. A.</i>		MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <i>MARYLAND</i>		b. COUNTY <i>A. A.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>PASADENA</i>		d. STREET ADDRESS <i>BODKIN CREEK</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Homewood Nursing Home</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>PAUL</i>		First	Middle	Last	4. DATE OF DEATH <i>FEB.</i>	Month	Day	Year <i>3 1957</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <i>FEB. 18, 1867</i>		9. AGE (In years lost birthday) 89 yrs.		10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i>	11. IF UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>WATER MAN</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>CRABBING</i>		11. BIRTHPLACE (State or foreign country) <i>BAVARIA</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>			
13. FATHER'S NAME <i>UNKNOWN</i>		14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No.</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>IRVINT. JOHNSON</i>		Address <i>Riviera Beach Kenwood Rd Mo</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>199.9</i>		DUE TO <i>ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 WKS.</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Metastatic Basal Cell Carcinoma</i>		(b) DUE TO <i>1. YEAR.</i>							
(c)									
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Arteriosclerotic Cardio-Vascular Disease</i>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) <i>3 FEB.</i> (State)			
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Edward S. Beck</i>						ADDRESS (Street, city or town, state) <i>Woodlawn Ave Baltimore Maryland</i>		DATE SIGNED <i>3 Feb 1957</i>	
PHYSICIAN'S NAME (Type) <i>Edward S. Beck</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>HOLY CROSS CEM</i>		22d. LOCATION (City, town, or county) <i>Ritchie Hwy AACo, Mo</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>FEB. 6, 1957</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>HOLY CROSS CEM</i>		22d. LOCATION (City, town, or county) <i>Ritchie Hwy AACo, Mo</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>George J. Force</i>		ADDRESS <i>4001 Ritchie Hwy</i>		24a. REC'D BY REGISTRAR DATE <i>2-6-57</i>		24b. REGISTRAR'S SIGNATURE <i>J. J. Force</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. It should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
FEB 7 1968
LIBRARY V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1415

CERTIFICATE OF DEATH

01413

Reg. Dist. No.

28

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		d. STREET ADDRESS Not given		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Walter	Middle 	Last Mosley	4. DATE OF DEATH 2	Month 2	Day 27	Year 1957		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown	9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Gravel Pit		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S.			
13. FATHER'S NAME Clem Mosley				14. MOTHER'S MAIDEN NAME Amy Richardson					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Mrs. Jessie Davis, daughter 205 E. 11th St., Wilmington, Delaware		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure									
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Arteriosclerosis									
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cancer of prostate gland									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m.		Month 19	Day 	Year 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Brewer Hill	20f. (City or town) Annapolis	(County) Md.	(State) Md.
21. I certify that I attended the deceased from 2/26 , 1957, to 2/27 , 1957, that I last saw the deceased alive on 2/26 , 1957, and that death occurred at 4:15 a.m. , from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) Crownsville, Md.									
DATE SIGNED 2/27/57									
ACTUAL SIGNATURE <i>Lionel McHenry Mapp.</i>									
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-2-57		22c. NAME OF CEMETERY OR CREMATORIUM Brewer Hill		22d. LOCATION (City, town, or county) Annapolis		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Joyce, Jr.</i>		ADDRESS Annapolis, Md.		24a. REC'D BY REGISTRAR DATE 2-28-57		24b. REGISTRAR'S SIGNATURE <i>E. M. Joyce</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01414

Item 3-5-2, G-211 - 3/5/57

1374

CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN lb 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ferndal, Glen Burnie, Maryland		d. STREET ADDRESS 4 Ferndale Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Louise	Middle Law	Last Nass	4. DATE OF DEATH	Month February	Day 22	Year 19 57
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-10-56 85	9. AGE (In years last birthday) 71 yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 71	Days 7	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY — — —		11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Gottlob Heinrich Seidle				14. MOTHER'S MAIDEN NAME Mina Caroline Schifferer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT John Nass		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Abscess with Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. 170X (b) Metastatic Carcinoma of Brain, Lung, and Liver DUE TO (c) Carcinoma of Breast (Right) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
						INTERVAL BETWEEN ONSET AND DEATH 1 week	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Annapolis, Maryland	(County) Annanolis Co
20g. (City or town) Annanolis Co		(State) Md					
21. I certify that I attended the deceased from 17 February, 19 57 , to 22 February, 19 57 , that I last saw the deceased alive on 22 February, 19 57 , and that death occurred at 3:00 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U. S. Naval Hospital DATE SIGNED 2/22/57							
ACTUAL SIGNATURE Vincent P. Butler, Jr.		M.D. U. S. Naval Hospital					
PHYSICIAN'S NAME (Type) Vincent P. Butler, Jr.		Annanolis, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 25-57		22c. NAME OF CEMETERY OR CREMATORIUM Silverbrook Cemetery		22d. LOCATION (City, town, or county) Wilmington, Del.	
23. FUNERAL DIRECTOR'S SIGNATURE J.T. Langston		ADDRESS Glen Burnie		24a. REC'D BY REGISTRAR RFB 27 1957		24b. REGISTRAR'S SIGNATURE J. French	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Item 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 27 1957

REVIEWED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
this page should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

V5 A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01415

1416. CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <i>Baltimore County</i>	2. USUAL RESIDENCE (Where deceased lived) b. STATE <i>Maryland</i>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Odegwater</i>	c. LENGTH OF STAY IN 1b <i>1 week</i>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>N/A</i>	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <i>Sarah Jane Neal</i>	4. DATE OF DEATH Month Day Year <i>2 27 1957</i>						
5. SEX <i>Female</i>	6. COLOR OR FACE <i>Chestnut</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-15-1881</i>	9. AGE (In years from birthday) yrs. <i>75</i>	10. IF UNDER 1 YEAR Months Days Hours Min. <i>0 0 0 0</i>	11. IF UNDER 24 HRS <i>0 0 0 0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic Service</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>N/A</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				
13. FATHER'S NAME <i>Richard Boston</i>	14. MOTHER'S MAIDEN NAME <i>Josie Watkins</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>74</i>	17. INFORMANT <i>Mary Layman Odegwater</i>	Address <i>626 Charles St., Baltimore, Md.</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>331 X</i>				INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour a. m. <i>19</i> p. m.	Month <i>Aug.</i>	Day <i>27</i>	Year <i>1957</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>626 Charles St., Baltimore, Md.</i>	20f. (City or town) (County) (State) <i>Baltimore, Md.</i>	
21. I certify that I attended the deceased from <i>5-24-57</i> , 19 <i>to 2-27-57</i> , 19 <i>that I last saw the deceased alive on 2-22-57</i> , 19 <i>and that death occurred at</i> <i>626 Charles St., Baltimore, Md.</i> from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <i>626 Charles St., Baltimore, Md.</i>	DATE SIGNED <i>27-3-57</i>
ACTUAL SIGNATURE <i>G. T. Kelly</i>							
PHYSICIAN'S NAME (Type) <i>AT ALTA</i>							
22. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>	22b. DATE THEREOF <i>3-2-57</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Claws Chapel</i>	22d. LOCATION (City, town, or county) (State) <i>Owensville, Md.</i>				
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Case, Jr., Annapolis, Md.</i>	ADDRESS <i>111 W. Church St., Annapolis, Md.</i>	24a. REC'D BY REGISTRAR <i>Date 4 1057</i>	24b. REGISTRAR'S SIGNATURE <i>Tom J. French</i>				

BUREAU Y.

MAR 4 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										01416	
CERTIFICATE OF DEATH										Reg. Dist. No. 14	
1. PLACE OF DEATH a. COUNTY A.A. MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MD. b. COUNTY A.A.						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sunset Beach			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sunset Beach			d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION											
3. NAME OF DECEASED (Type or print)		First PATRICIA		Middle ANN NOLAN		Lost		4. DATE OF DEATH 2/1/57	Month	Day	Year 19
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/30/55 56		9. AGE (In years (at birthday) Yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Maryland Balto. City			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Thomas			14. MOTHER'S MAIDEN NAME Margaret Squires								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT		Address					
Family - Same											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute bronchopneumonia</i> INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>											
491X Conditions, if any, which gave rise to immediate cause (a), slothing the under- lying cause lost. (b) _____ DUE TO _____ (c) _____ DUE TO _____ Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <i>January 31, 1957</i> , to <i>Feb 1, 1957</i> , that I last saw the deceased alive on <i>January 31, 1957</i> , and that death occurred at <i>6:00 AM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>R.M. McLaughlin</i> M.D. ADDRESS (Street, city or town, state) <i>RED 8 Box 442 Pasadena Feb 1 1957</i> DATE SIGNED PHYSICIAN'S NAME (Type) <i>R.M. McLaughlin</i>											
22a. BURIAL, CREMATION, REMOVAL (Specify) B		22b. DATE THEREOF 2/4/57		22c. NAME OF CEMETERY OR CREMATORIUM Holy Cross		22d. LOCATION (City, town, or county) Baltimore		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Homes - 130 E. Fort Ave.		ADDRESS 2046 321 XV 5		24a. REC'D BY REGISTRAR FED 1 1957		24b. REGISTRAR'S SIGNATURE L.J. DeMaggio					
VS A15 (4) 15M 9/55											

RECEIVED
FEB 4 19

FEDERAL BUREAU OF INVESTIGATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1375 CERTIFICATE OF DEATH

01417

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page ■
 may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>A.A.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b e. STREET ADDRESS <i>Arth Station</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>A.C. General</i>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Della</i>	Middle <i>Mae</i>	Last <i>North</i>		
4. DATE OF DEATH	Month <i>2</i>	Day <i>1</i>	Year <i>1957</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4-24-1882</i>		
9. AGE (In years last birthday) <i>74 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. IF UNDER 24 HRS Hours <i>0</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	11. BIRTHPLACE (State or foreign country) <i>Benwood West Va</i>	12. CITIZEN OF WHAT COUNTRY? <i>N. S. A.</i>		
13. FATHER'S NAME <i>Jacob Strober</i>	14. MOTHER'S MAIDEN NAME <i>Emma Marshall</i>	Address <i>Charles H. North</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>144-2X</i>	17. INFORMANT <i>Charles H. North</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>uremia</i> DUE TO <i>442X</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. <i>arteriosclerotic cardio-vascular renal disease</i> DUE TO (b) (c)	INTERVAL BETWEEN ONSET AND DEATH <i>6 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>cirrhosis of liver</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Ames Garrett Blvd., Annapolis, Md.</i>	20f. (City or town) <i>Baltimore</i>	(County) <i>Md</i>	(State) <i>Md</i>
21. I certify that I attended the deceased from <u>May 1943</u> , 19 <u>57</u> , to <u>Feb. 1</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Feb. 1</u> , 19 <u>57</u> , and that death occurred at <u>1:50 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <i>S. Borssuck</i> M.D. <i>Ames Garrett Blvd., Annapolis, Md. 2/3/57</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>2-4-57</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>London Park</i>	22d. LOCATION (City, town, or county) <i>Baltimore</i>	(State) <i>Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i>	ADDRESS <i>Annapolis Md.</i>	24a. REC'D. BY REGISTRAR DATE <i>2/5/57</i>	24b. REGISTRAR'S SIGNATURE <i>John M. Taylor Sons</i>		

REAU V.

FEB 7

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1376

CERTIFICATE OF DEATH

01418

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
a a MARYLAND		Md a a	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Annapolis		Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
1019 Severn Ave.	1019 Severn Ave.		
3. NAME OF DECEASED (Type or print)	First	Middle	Last
Adalbert	J.	Oktavec	
4. DATE OF DEATH	Month	Day	Year
	2	28	1957
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	4-14-1880
9. AGE (In years less birthday) yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
76	Months	Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Tool MAKER	U.S. Govt Ref.	CZECHOSLOVAKIA	U.S.
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
John OKTAVEC	Mary BLAKA		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
—	—	AGNES M. OKTAVEC #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			
45.0	DUE TO	Congestive heart failure; pulmonary edema	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.	(b)	Arteriosclerosis, heart disease	
	DUE TO		
	(c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY	Month, Day, Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Hour a. m. p. m.	19	While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1 Jan</u> , 1957, to <u>28 Feb</u> , 1957, that I last saw the deceased alive on <u>28 Feb</u> , 1957, and that death occurred at <u>815A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE	ADDRESS (Street, city or town, state)		DATE SIGNED
EDWARD S. RECK	41 Southgate Ave		3/1/57
PHYSICIAN'S NAME (Type)	EDWARD S. RECK MD ANNAPOLIS, MARYLAND		
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIAL	22d. LOCATION (City, town, or county) (State)
Burial	3-2-57	St. Marys	Annapolis Md
23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
John W. Taylor Son	1019 Severn Ave.	MAR 2 1957	U. W. W. W.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page _____ may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Postage and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

FILM V. 8

MAR 5 1957

REGAL VIDEO

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1377

CERTIFICATE OF DEATH

01419

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission)	
<i>Anne Arundel MARYLAND</i>		a. STATE	<i>Maryland A.A.</i>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1B	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>Annapolis</i>		<i>Dawsonville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
<i>A. A. General Hosp.</i>			
3. NAME OF DECEASED (Type or print)	First <i>Galloway</i>	Middle <i>Parker</i>	4. DATE OF DEATH Month 2 Day 20 Year 1957
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Col</i>	7. MARRIED NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. B. DATE OF BIRTH <i>5-1-1893</i>
9. AGE (In years last birthday) yrs. <i>63</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. IF UNDER 24 HRS Hours <i>0</i>
13. FATHER'S NAME <i>Nelson Parker</i>	14. MOTHER'S MAIDEN NAME <i>Bobbie Parker</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, <input type="checkbox"/> No, <input type="checkbox"/> None) Ill yes, give war or dates of service <i>No</i>	
16. SOCIAL SECURITY NO. <i>217-30-3093</i>	17. INFORMANT <i>Lucy Parker-Davidsonville</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiovascular accident</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Crown hypertension</i> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19			
21. I certify that I attended the deceased from <i>2/18</i> , 19 <i>57</i> to <i>2/20</i> , 19 <i>57</i> that I last saw the deceased alive on <i>2/18</i> , 19 <i>57</i> , and that death occurred at <i>8:15</i> M, from the causes and on the date stated above.			
PHYSICIAN'S NAME (Type)		ADDRESS (Street, city or town, state) <i>John L. Hedwaren M.D.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial 2-25-57</i>		22b. DATE THEREOF <i>2-25-57</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Adams Chapel Beyond, Md.</i>		22d. LOCATION (City, town, or county) (State) <i>Adams Chapel Beyond, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Giese Jr. - Annapolis, Md.</i>		24a. REGD. BY REGISTRAR DATE <i>FEB 26 1957</i>	
ADDRESS <i>William Giese Jr. - Annapolis, Md.</i>		24b. REGISTRAR'S SIGNATURE <i>J.W. Duncy</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Part 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1378

CERTIFICATE OF DEATH

01420
Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>15 Lee St.</i>		d. STREET ADDRESS <i>15 Lee St.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Peter</i>	Middle <i>J.</i>	Last <i>Peters</i>
4. DATE OF DEATH	Month <i>2</i>	Day <i>9</i>	Year <i>1957</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Col.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-9-1892</i>
9. AGE (In years lost birthday) yrs. <i>64</i>	10. IF UNDER 1 YEAR Months <i>12</i>	11. IF UNDER 24 HRS. Days <i>12</i>	12. Hours <i>12</i>
13. COUNTRY <i>U.S.A.</i>	10a. USA OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		
10b. KIND OF BUSINESS OR INDUSTRY <i>Construction</i>		11. BIRTHPLACE (State or foreign country) <i>C.C.C. Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>George A. Peters</i>	
14. MOTHER'S MAIDEN NAME <i>Ella Ford</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input type="checkbox"/> (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>216-28-0755</i>		17. INFORMANT <i>Therionna Peters (Annapolis) Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>443x</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) Hyper tension Cardiovascular Dis		DUE TO <i>Central Hemorrhage</i> 4 years	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Jan 30, 1957</i> to <i>Feb 9, 1957</i> that I last saw the deceased alive on <i>Feb 8, 1957</i> , and that death occurred at <i>3 a.m.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>62 Cathedral</i>	
ACTUAL SIGNATURE <i>Fay W Allen M.D.</i>		DATE SIGNED <i>2-11-57</i>	
PHYSICIAN'S NAME (Type) <i>FAYE WALLEN</i>		ANNE ARUNDEL MD	

22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>2-13-57</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Fowler Chapel</i>	22d. LOCATION (City, town or county) (State) <i>Baltimore Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Pease, Jr. - Annapolis, Md.</i>		ADDRESS <i>101 W. Church St.</i>	
		24a. REC'D BY REGISTRAR <i>Dr. Wm. French</i>	24b. REGISTRAR'S SIGNATURE <i>Dr. Wm. French</i>
		DATE <i>2/15/57</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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25.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
BURIAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Part 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Part 1 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01421

1418

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>A.A.</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i>		b. COUNTY <i>AA</i>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>CHALIN PT. WEST River, Md.</i>		c. LENGTH OF STAY IN 1b <i>60 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>CHALIN PT. WEST RIVER, Md.</i>		d. STREET ADDRESS <i>/</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>WILSON</i>		First <i></i>	Middle <i></i>	Last <i>PHIPPS</i>	4. DATE OF DEATH <i>Feb. 2</i>	Month <i>Feb.</i>	Day <i>2</i>	Year <i>1957</i>				
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 2 1871</i>		9. AGE (In years last birthday) <i>86 yrs.</i>	10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 HRS. Days <i></i>	Hours <i></i>	Min. <i></i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>OYSTER + FARM</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>DEALE, MD</i>		12. CITIZEN OF WHAT COUNTRY?						
13. FATHER'S NAME <i>F. NICKALAS</i>		14. MOTHER'S MAIDEN NAME <i>LOUISA KIRCHNER</i>										
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>Louis N. Phipps 67 College Ave, Annapolis MD.</i>		Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4841</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i></i>		DUE TO <i>i. pneumonia, left upper lobe</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>								
(b) <i></i>		DUE TO <i>ii. ingestive failure</i>		3 years								
(c) <i></i>												
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Generalized arterio sclerosis</i>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i></i>										
20c. TIME OF INJURY Hour a. p.m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>		20f. (City or town) <i>Shady Side</i>		(County) <i>Shady Side</i>		(State) <i>Maryland</i>		
21. I certify that I attended the deceased from <i>Feby</i> , 19 <i>57</i> , to <i>a Shady Side</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>in January</i> 19 <i>57</i> , and that death occurred at <i>4:00 P.M.</i> from the causes and on the date stated above.							ADDRESS (Street, city or town, state) <i>Shady Side, Maryland</i>					DATE SIGNED <i>4 Feb 57</i>
ACTUAL SIGNATURE <i>F.D.H. Hendricks</i>		M.D.										
PHYSICIAN'S NAME (Type) <i>F.D. Hendricks</i>												
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>2/4/57</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>St. James</i>		22d. LOCATION (City, town, or county) <i>Tracy's - 82 Co. Md.</i>		(State) <i>MD.</i>				
23. FUNERAL DIRECTOR'S SIGNATURE <i>BERNARD Hardisty Edlesville Md.</i>		ADDRESS <i></i>		24a. REC'D BY REGISTRAR <i>J. J. French</i>		24b. REGISTRAR'S SIGNATURE <i>J. J. French</i>			DATE <i>1/1/57</i>			

BUREAU V. A.

FEB 11 1957

MEMO

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01422

1419

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore City		
Crownsville		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town)		c. LENGTH OF STAY IN lb 2mos.18days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS 2605 Spellman Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Emma		First	Middle	Last	4. DATE OF DEATH Powell	Month	Day	Year
5. SEX Female		6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/12/03 ?		9. AGE (In years last birthday) 53 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY - - -		11. BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY U. S.		
13. FATHER'S NAME Not given		14. MOTHER'S MAIDEN NAME Mahalia Pinkett						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Unk. Hospital Records		State Hospital Crownsville, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia						INTERVAL BETWEEN ONSET AND DEATH		
442X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		(b) DUE TO Hypertensive cardiovascular renal disease						
		(c) DUE TO						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypostatic Pneumonia						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Crownsville	(County)	(State)	
21. I certify that I attended the deceased from		2/27	19 57	to	2/28	19 57	that I last saw the deceased alive on	
alive on 2/28 1957		and that death occurred at 11:15 a.m.		ADDRESS (Street, city or town, state)		DATE SIGNED		
ACTUAL SIGNATURE <i>Lionel McHenry Mapp</i>				Crownsville, Md.		2/28/57		
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp								
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 3/4/57	22c. NAME OF CEMETERY OR CREMATORIUM Mt. Calvary	22d. LOCATION (City, town, or county) Baltimore		(State) Md.		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Geo M. Kelsen 1348n Calvert St</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE 3/5/57		24b. REGISTRAR'S SIGNATURE <i>J. M. Joyce</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

PRIMAVERA

1954

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1420

CERTIFICATE OF DEATH

01423 ny

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
Anne Arundel Maryland		Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
OCHARD BEACH	7 yrs.	OCHARD BEACH	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS		
7800 High Point Rd.	7800 High Point Rd.		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First	Middle	Last
Alice J. Powers			
4. DATE OF DEATH	Month	Day	Year
FEB. 25			1957
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
FEMALE White			Oct. 31, 1874
9. AGE (in years last birthday) yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. KIND OF BUSINESS OR INDUSTRY	12. BIRTHPLACE (State or foreign country)
82	Housewife		Baltimore, Md. U.S.
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
Samuel Taylor	Rose Garvey		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
No.		JOSEPH S. TAYLOR	7800 High Pt. Rd. AAC.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute pulmonary edema</i> DUE TO <i>Arteriosclerotic Cardiovascular disease</i> INTERVAL BETWEEN ONSET AND DEATH <i>26 hours</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <i>Arteriosclerotic Cardiovascular disease</i> 7 years. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
cerbro-vascular accident - 1930			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>April 10, 1950</i> , to <i>Feb. 25, 1957</i> , that I last saw the deceased alive on <i>Feb. 24, 1957</i> , and that death occurred at <i>2:11 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>R. M. McLaughlin</i>		ADDRESS (Street, city or town, state) <i>Pasadena, Maryland</i> DATE SIGNED <i>Feb. 25, 1957</i>	
PHYSICIAN'S NAME (Type) <i>R. M. McLaughlin</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM	22d. LOCATION (City, town, or county) (State)
BURIAL	Feb 27, 1957	NEW CATHEDRAL CEM	BALTIMORE, MD
23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
George J. Force	4001 RITCHIE Hwy	GR 1	DATE 1957 L. J. DeAlley

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Line 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BUREAU V.

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REGISTRY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1421

CERTIFICATE OF DEATH

Reg. Dist. No. 42428

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 6rs. 5mos. 10days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		d. STREET ADDRESS 1324 Orleans St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Miranda	Middle	Lost	4. DATE OF DEATH	Month 2	Day 10	Year 19 57
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/1/79	9. AGE (In years less birthday) 77 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - -		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Kane Jacobs				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Hospital Records		Address State Hospital Crownsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia							
442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Arteriosclerotic cardiovascular-renal disease							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Dehydration, Malnutrition, Decubitus ulcers							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/10 , 19 57 , to 2/10 , 19 57 , that I last saw the deceased alive on 2/8 , 19 57 , and that death occurred at 2:30 a.m. from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Lionel McHenry Mapp</i> M.D.							
ADDRESS (Street, city or town, state) Crownsville, Md.							
DATE SIGNED 2/10/57							
22a. BURIAL, CREMATION, REMOVAL (Specify) 2-14-57		22b. DATE THEREOF 2-14-57		22c. NAME OF CEMETERY OR CREMATORIUM Mt Cal.		22d. LOCATION (City, town, or county) Baltimore, Md., area.	
23. FUNERAL DIRECTOR'S SIGNATURE C. Nelson 1000 Brandy St.				ADDRESS		24a. REC'D BY REGISTRAR DATE EB 13 1957	
						24b. REGISTRAR'S SIGNATURE A. M. Joyce	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
1957

RECEIVED

1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01425

Reg. Dist. No.

1379

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Carvel Hall</i>		d. STREET ADDRESS <i>Carvel Hall</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>F. Elizabeth</i>	Middle <i>Pumphrey</i>	Last <i>1882</i>
4. DATE OF DEATH Month <i>2</i>	Day <i>2</i>	Year <i>1957</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-25-1882</i>
9. AGE (in years on birthday) <i>74 yrs.</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Tey nurse</i>	11. KIND OF BUSINESS OR INDUSTRY <i>Tey nurse</i>	12. BIRTHPLACE (State or foreign country) <i>Maryland</i>
13. CITIZEN OF WHAT COUNTRY? <i>USA</i>	14. MOTHER'S MAIDEN NAME <i>Hannie Lienieser</i>		
15. FATHER'S NAME <i>Thomas Winter Pumphrey</i>	16. SOCIAL SECURITY NO. <i>- - -</i>		
17. INFORMANT <i>Mrs. Henry E. Smith</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage.</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. <i>(b)</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Seizures</i>		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Blindfolded</i>	20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) <i>Baltimore</i>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>E. Linhardt</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
DATE SIGNED <i>2/2/57</i>			
22a. BURIAL CREMATION REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>2-5-57</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Hill</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John W. Taylor</i>	ADDRESS <i>Annapolis</i>	24a. REC'D BY REGISTRAR DATE <i>2/5/57</i>	24b. REGISTRAR'S SIGNATURE DATE <i>John W. Taylor</i>

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the remains or removal.

REVIEW FILE

FEB 7

LIBRARY X. S.

INSTRUCTIONS

TO FINDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the funeral director, the third copy of this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 155-10A

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01426

1422 CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR TOWN end give nearest town)	MARYLAND LENGTH OF STAY (In this place)	STATE Maryland CITY (If outside corporate limits, write RURAL and give nearest town)	COUNTY Anne Arundel TOWN Glen Burnie STREET ADDRESS (If rural give location)
Anne Arundel Brent - Glen Burnie	77 yrs	Maryland Brent - Glen Burnie	Mackey Station Rd, Glen Burnie, Po
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Mackey Station Rd, Glen Burnie, Po		
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
Louis Edgar Pumphrey		(Month) Feb	(Day) 10
(First) Louis		(Middle) Edgar	(Year) 1957
S. SEX Male	6. CO-OP OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH August 15, 1879
10. USUAL OCCUPATION? (Give kind of work done during most of working life, even if retired) Real ESTATE	10b. KIND OF BUSINESS OR INDUSTRY Garage	11. BIRTHPLACE (State or foreign country) Mackey Station Rd, Glen Burnie	12. CITIZEN OF WHAT COUNTRY? A.B.A.
13. FATHER'S NAME Osborne Stallings Pumphrey	14. MOTHER'S MAIDEN NAME Jeannera Stump Robinson		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No	16. SOCIAL SECURITY NO. No 78	17. INFORMANT & ADDRESS Anne Wilson Pumphrey-Same	INTERVAL BETWEEN ONSET AND DEATH 30 MIN
II DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) Respiratory Failure	ANTECEDENT CAUSE(S) DUE TO Congestive Heart Failure	1 hr.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) (C) Coronary Occlusion			85 days
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Senility			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from alive on....., 1957, to....., 1957, that I last saw the deceased			
alive on....., 1957, and that death occurred at....., M, from the causes and on the date stated above.			
SIGNATURE <i>W. Richard</i>		ADDRESS (Street, city, town, state) <i>715 Cather Rd, Glen Burnie, Md.</i>	DATE SIGNED <i>2/10/59</i>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF Feb. 13, 1957	NAME OF CEMETERY OR CREMATORIAL Cedar Hill	LOCATION (City, town, or county) Brooklyn Rd, Md.
24. REC'D BY REGISTRAR DATE Feb 12, 1957	REGISTRAR'S SIGNATURE <i>L. L. Davis</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>R. Langston</i> ADDRESS <i>Glen Burnie, Md.</i>	

2. V. 2

2. V. 2

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01427

1423 CERTIFICATE OF DEATH

Reg. Dist. No. 27

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M - 8

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	ANNE ARUNDEL Fort G. G. Meade	MARYLAND DOA	STATE Maryland CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN STREET ADDRESS
HOSPITAL OR INSTITUTION OR STREET ADDRESS	1929 E. Reece Road		
3. NAME OF (First) WINIFRED (Middle) ANN (Last) BAI (Type or Print)	4. DATE OF DEATH 6 February 1957		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGL^E, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH 28 July 1921
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10f. KIND OF BUSINESS OR INDUSTRY None	9. AGE last birthday 35 Yr yrs.
13. FATHER'S NAME Joseph Francis Murray		14. MOTHER'S MAIDEN NAME Alice Cecilia Nevins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT & ADDRESS Husband, 1929 E. Reece Road, Fort George G. Meade, Maryland
II DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
420.1 IMMEDIATE CAUSE (A) Coronary Occlusion			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) _____ GIVING RISE TO THE ABOVE CAUSE DUE TO STATING UNDERLYING CAUSE LAST. DUE TO (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) U.S. Army Hospital (State) Wash D.C.
21d. TIME OF INJURY (Month) Feb (Day) 6 (Year) 1957 (Hour) M.	21e. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 6 Feb 1957 to 19 , that I last saw the deceased alive on 6 Feb 1957 , and that death occurred at 11:55 P.M. from the causes and on the date stated above. SIGNATURE S. H. Tarabishy ADDRESS (Street, city, town, state) U. S. Army Hospital DATE SIGNED 6 Feb 1957			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF 2-11-57 Arlington	NAME OF CEMETERY OR CREMATORIAL Wash D.C.	LOCATION (City, town, or county) (State)
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE W.L. Saylor	25. FUNERAL DIRECTOR'S SIGNATURE Thomas S. Lovell	ADDRESS
DATE 7 Feb 57	W.M. COCK, INC., Baltimore, Maryland		

BUREAU V. S.

FEB 11 19

Kennebunk

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01428

1424

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 22 yrs. 1mo. 15da.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		d. STREET ADDRESS 900 Lake St., Extended			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Dorothy	Middle	Last Robbins	4. DATE OF DEATH 2	Month 8	Day Year 1957		
S. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/12/08	9. AGE (in years last birthday) 49 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S.			
13. FATHER'S NAME Jack Dennis				14. MOTHER'S MAIDEN NAME Bessie Toadvine					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Hospital Records		Crownsville State Hosp. Crownsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Damage DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c)									
INTERVAL BETWEEN ONSET AND DEATH									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at home <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1/25 , 19 48 , to 2/8 , 19 57 , that I last saw the deceased alive on 2/7 , 19 57 , and that death occurred at 3:45a M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md.								DATE SIGNED 2/8/57	
ACTUAL SIGNATURE Ludwig Benedict, M. D.		M.D.							
PRINTED NAME (Type) h. ludwig benedict									
22a. BURIAL, CREMATION, REMOVAL (Specify) 2/11/57		22b. DATE THEREOF 2/11/57		22c. NAME OF CEMETERY OR CREMATORIAL Green Acres		22d. LOCATION (City, town, or county) Salisbury (State) Md.			
22e. FUNERAL DIRECTOR'S SIGNATURE Stewart Funeral Home Salisbury Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE 2/10/57		24b. REGISTRAR'S SIGNATURE Katherine Joyce			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

S. V. S.

Oliver

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01429

1380

CERTIFICATE OF DEATH

Reg. Dist. No. 21

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		d. STREET ADDRESS 45 Madison Place	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First ANDREW	Middle L	Last ROBINSON	4. DATE OF DEATH	Month FEBRUARY	Day 3	Year 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH June 23, 1880	9. AGE (In years lost birthday) 76 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Pipe fitter		10b. KIND OF BUSINESS OR INDUSTRY US Gov.		11. BIRTHPLACE (State or foreign country) Annapolis, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Robinson		14. MOTHER'S MAIDEN NAME Rebecca Puckett					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs Madalene Robinson- Wife- Same as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Bronchopneumonia</i> DUE TO (c) <i>Carcinoma of Lung Metastatic</i>						INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ARTERIOSCLEROTIC HEART DISEASE						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Annapolis	(County) Anne Arundel	(State) Maryland
21. I certify that I attended the deceased from Mar. 1957 , to 3 FEB 1957 , that I last saw the deceased alive on 3 FEB 1957 , and that death occurred at 11 AM , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) Southgate Ave, Annapolis, Md.		DATE SIGNED	
ACTUAL SIGNATURE <i>Edward S. Beck MD</i>	Edward S. Beck						
INTERCAMP NAME (Type)		Edward S. Beck					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-5-57	22c. NAME OF CEMETERY OR CREMATORIAL St. Mary's Cemetery		22d. LOCATION (City, town, or county) Annapolis		(State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. L. Inc. Funeral Home</i>		ADDRESS Annapolis, Md.		24a. REC'D BY REGISTRAR 2/5/57		24b. REGISTRAR'S SIGNATURE <i>J. French</i>	

BUREAU Y. & S.

FEB 7 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1425

CERTIFICATE OF DEATH

Reg. Dist. No.

014304

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY A.A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Nelson Island	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Skinner Row		d. STREET ADDRESS Skinner Row	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Kessel	Middle Jose	Last Savitz
4. DATE OF DEATH EOM. Feb. 5 1957	Month	Day	Year
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 30, 1894
9. AGE (In years less birthday) 62 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fruit Seller.		10b. KIND OF BUSINESS OR INDUSTRY Doughnut Mill	
10c. BIRTHPLACE (State or foreign country) Penn.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Jerome J. Savitz		14. MOTHER'S MAIDEN NAME Savella F. --	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Re/ M.C. Service Gioco Island		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		generalized carcinomatosis Carcinoma of prostate 8 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 1956, to <u>February 6, 1957</u> that I last saw the deceased alive on <u>January 30, 1957</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) Karl F. Mech, M.D. 112. Chase St., Balt-2, M.D. DATE SIGNED ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) KARL F. MECH, M.D. 11 E. CHASE ST., BALTO-2, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 2-3-57	
22c. NAME OF CEMETERY OR CREMATORIAL Lawn-on-Park Crematory		22d. LOCATION (City, town, or county) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE John J. DeAlba, Esq., Trustee		24a. REC'D. BY REGISTRAR DATE 11-1957	
ADDRESS		24b. REGISTRAR'S SIGNATURE John J. DeAlba	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Postage and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

BUREAU V. S.

FEB 11 1957



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01431
21

Reg. Dist. No.

1426

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Same		b. COUNTY Same		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b 16 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Same		d. STREET ADDRESS Box 1215 Dorsey Road		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS Same		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Anna Marie Shenton		First	Middle	Last	4. DATE OF DEATH February 1st.	Month	Doy	Year
5. SEX F		6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 7/11/17	9. AGE (in years last birthday) 39 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Samuel Wilkinson		14. MOTHER'S MAIDEN NAME Anna Smith						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-18-8443		17. INFORMANT Norman Shenton (husband)		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Strangulation by hanging herself to the railing INTERVAL BETWEEN ONSET AND DEATH								
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) On the back porch of her home with a belt. Sudden								
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hanging herself to the railing of porch with a belt.						
20c. TIME OF INJURY Month, Day, Year Hour o. m. 20d. INJURY OCCURRED While at work Not while at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Back porch of home, Glen Burnie, A.A. Md.		20f. (City or town) Glen Burnie, A.A. Md.		(County) A.A. Md.		(State) Md.		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>Gustave H. Faubert, M.D.</i>		DATE SIGNED February 4th, 1957						
EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF <16/57		22c. NAME OF CEMETERY OR CREMATORIUM Loudon Park Cemetery		22d. LOCATION (City, town, or county) Baltimore, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. J. Hopping</i>		ADDRESS Hopping and Kirkley Funeral Home, Glen Burnie,		24e. REC'D. BY REGISTRAR FEB 8 1957		24f. REGISTRAR'S SIGNATURE <i>L. J. DeAlba</i>		
VS. AFMSE(S) SM 9/55				DATE				

2000

Page V. S

EE3

1970

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, portion should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01432

1427

CERTIFICATE OF DEATH

Reg. Dist. No. 88

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville	c. LENGTH OF STAY IN lb 5 mos. 1 day	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		d. STREET ADDRESS 2216 Druid Hill Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Rachel Davenport Middle Smith		4. DATE OF DEATH Month 2 Day 12 Year 1957	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> b. DATE OF BIRTH 2/25/1918 1896	9. AGE (In years last birthday) 60 yrs. IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY --	11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? U. S.			
13. FATHER'S NAME ISAAC Davenport		14. MOTHER'S MAIDEN NAME Linda Davenport	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. Unk.	17. INFORMANT Hospital Records State Hospital Address Crownsville, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH Cerebral Thrombosis	
445X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		Hypertensive Arteriosclerotic Cardiovascular Disease	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pyelitis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. p.m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2/2, 1957, to 2/12, 1957, that I last saw the deceased alive on 2/11, 1957, and that death occurred at 4:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Lionel McHenry Mapp.	M.D.	ADDRESS (Street, city or town, state) Crownsville, Md.	DATE SIGNED 2/13/57
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb. 16, 1957	22c. NAME OF CEMETERY OR CREMATORY Shiloh Cemetery	22d. LOCATION (City, town, or county) Northumberland Co., Va. (State)
23. FUNERAL DIRECTOR'S SIGNATURE Joseph L. Russ		ADDRESS 2222 W. North Ave	24a. REC'D BY REGISTRAR DATE 13 1957
			24b. REGISTRAR'S SIGNATURE F. M. Joyce

Y. S.

3.

1965

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01433

1381

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE	
<i>Anne Arundel MARYLAND</i>		<i>Maryland A.A.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1B	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>Annapolis</i>		<i>Annapolis</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
<i>St. J. Bx 64</i>	<i>St. J. Bx 64</i>		
3. NAME OF DECEASED (Type or print)	First	Middle	Last
<i>John R. Thomas</i>			
4. DATE OF DEATH	Month	Day	Year
	2	14	1957
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
<i>Male Col.</i>			<i>8-25-1872</i>
9. AGE (in years to nearest birthday)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. Hours
<i>34 yrs.</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	12. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
<i>Farming</i>	<i>Self</i>	<i>A.A. Co. Md.</i>	<i>U.S.A.</i>
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
<i>John R. Thomas</i>	<i>Zachel Thomas</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO	17. INFORMANT	Address
<i>No</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)			
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]	
20c. TIME OF INJURY Month, Day, Year Hour o.s. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>July 27, 19</i> to <i>Sept 14, 19</i> , that I last saw the deceased alive on <i>Aug 13, 19</i> , and that death occurred at <i>3:30 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Skidmore, Md.</i> DATE SIGNED <i>G.T. Allis</i> M.D. <i>Oct 14, 1957</i> <i>1957</i>			
ACTUAL SIGNATURE <i>G.T. Allis</i>		22d. LOCATION (City, town, or county) (State) <i>Skidmore, Md.</i>	
PHYSICIAN'S NAME (Type) <i>G.T. Allis</i>		22e. NAME OF CEMETERY OR CREMATORIUM <i>Broad Neck</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial 2-17-57</i>		22b. DATE THEREOF <i>2-17-57</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Seese, Jr-Annapolis</i>		24a. REC'D BY REGISTRAR DATE <i>Oct 16, 1957</i>	
		24b. REGISTRAR'S SIGNATURE <i>Tom J. Murphy</i>	

WINGFIELD

BUREAU V. S.

FEB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01434

1382

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2. Arnold		d. STREET ADDRESS 139 Clifton Ave	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First MARY	Middle LOU	Last THOMAS	4. DATE OF DEATH Feb. 17, 1957	Month 19	Day	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Feb. 8, 1957	9. AGE (In years last birthday) yrs 8	IF UNDER 1 YEAR Months 8	IF UNDER 24 HRS. Days 8	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Annapolis, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Rx George Thomas		14. MOTHER'S MAIDEN NAME Patercia R. Kenline		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mr George Thomas -Father- same and # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity DUE TO						INTERVAL BETWEEN ONSET AND DEATH 9 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. p.m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from 2/14/57 to 2/17/57 that I last saw the deceased alive on Feb. 14, 1957 , and that death occurred at 2 P.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE Melvin H. Sims		M.D.					
PHYSICIAN'S NAME (Type) Noell Sims MD		95 Cathedral St., Annapolis, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-18-57		22c. NAME OF CEMETERY OR CREMATORIUM St. Mary's		22d. LOCATION (City, town, or county) (State) Annapolis, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Deasy Jr.		ADDRESS HOPPING FUNERAL HOME		24a. REC'D. BY REGISTRAR FEB 20 1957		24b. REGISTRAR'S SIGNATURE John J. Deasy	
VS A15 (4) 1SM 9/55							

MEAU V. S.

EB 90 1057

REGELV E

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC I-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01435

1428 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS	MARYLAND LENGTH OF STAY (in this place)	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN STREET ADDRESS	COUNTY MD. ODENTON (If rural give location)
3. NAME OF DECEASED (First) ROY LEE THOMAS, II (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH FEB 19, 1957	
5. SEX MALE	6. COLOR OR RACE CAUCASIAN	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) —	8. DATE OF BIRTH FEB 6, 1957
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MARYLAND
13. FATHER'S NAME ROY LEE THOMAS		14. MOTHER'S MAIDEN NAME KAYE MARSDEN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) —		16. SOCIAL SECURITY NO. —	
17. INFORMANT & ADDRESS FATHER, ROY LEE THOMAS,		18. MEDICAL CERTIFICATION <i>Prematurity</i> ↑ <i>Anoxia</i> ↓ <i>Probable intracranial hemorrhage</i> Estimated 13 days.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) —	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21c. WHERE DID INJURY OCCUR? (City or town) (County) —	
		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>6 Feb</i> 1957 to <i>19 Feb</i> 1957, that I last saw the deceased alive on <i>19 Feb</i> 1957, and that death occurred at <i>5:35 P.M.</i> from the causes and on the date stated above.			
SIGNATURE <i>Richard M. McGuane</i> M.D.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>2-21-57</i> NAME OF CEMETERY OR CREMATORIAL <i>Baltimore National</i> LOCATION (City, town, or county) <i>BALTO MD.</i> (State)	
24. REC'D BY REGISTRAR DATE <i>FEB 19, 57</i>		REGISTRAR'S SIGNATURE <i>W.H. Saylor, R.T.L. MSC.</i> 25. FUNERAL DIRECTOR'S SIGNATURE <i>William Cook</i> ADDRESS <i>Maryland</i>	

BUREAU V. S.

EEB 22 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01436

1383

CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE					
<i>Anne Arundel MARYLAND</i>		<i>Maryland A.A.</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
<i>Annapolis</i>		<i>Gambills</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
<i>A.C. General Hosp.</i>							
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
<i>Stesley</i>			<i>Turner</i>	2	21	31	1957
5. SEX	6. COLOR OR FACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years lost birthday) yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS		
<i>Male</i>	<i>Col</i>		<i>2-3-1882</i>	75	Months Days Hours Min.		
10a. US. OCCUPATION (Give kind of work done during part of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Laborer</i>		<i>U.S. Naval Acad.</i>		<i>Baltimore, Md.</i>		<i>U.S.A.</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
<i>Tim Turner</i>		<i>Oliva Hamilton</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
<i>No</i>		<i>—</i>		<i>Ethel Turner - Gambills, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)							
DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)							
DUE TO							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>2-9-57</i> to <i>2-21-57</i> , 19, that I last saw the deceased alive on <i>2-10-57</i> , 19, and that death occurred at <i>M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>A.T. Colby</i> ADDRESS (Street, city or town—state) <i>61 E. Ward St.</i> DATE SIGNED <i>2-23-57</i>							
PHYSICIAN'S NAME (Type) <i>A.T. Colby</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CEMATORIAL		22d. LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>2-24-57</i>		<i>Mt.abor</i>		<i>Chesterfield, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. RECEIVED BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE	
<i>William Giese - Annapolis, Md.</i>				<i>FEB 26 1957</i>		<i>Wm. J. French</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Part 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Part 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU A. S.

FEB 09 1957



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01437

1429

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linthicum		c. LENGTH OF STAY IN lb 4 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Linthicum		d. STREET ADDRESS 205 S. Hammonds Ferry Rd.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 205 S. Hammonds Ferry Road						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Mae Commie Ward		First	Middle	Last	4. DATE OF DEATH February 7, 1957	Month	Day	Year
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	8. DATE OF BIRTH Sept. 25/97	9. AGE (In years lost birthday) 59 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cleaning (ret.)		10b. KIND OF BUSINESS OR INDUSTRY Beshan Vet. Hosp.		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Sam Woods				14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 191 20 4944		17. INFORMANT Mrs. Mary Jane Ward		Address Same As #2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 445X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO (b) Chronic Nephro-Sclerosis				INTERVAL BETWEEN ONSET AND DEATH 4 days		
DUE TO (c) Malignant Hypertension						4 yrs.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 106 W. Maple Road		(County) Baltimore (State) Maryland
21. I certify that I attended the deceased from July 24, 1952 , to Feb. 7, 1957 , that I last saw the deceased alive on Feb. 3, 1957 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 106 W. Maple Road DATE SIGNED 2/8/57								
ACTUAL SIGNATURE <i>C. Milton Linthicum</i>		M.D.						
PHYSICIAN'S NAME (Type) C. Milton Linthicum				Linthicum Heights, Maryland				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 11/57		22c. NAME OF CEMETERY OR CREMATORIUM Greenwood Cemetery		22d. LOCATION (City, town, or county) Sharpsburg, Pennsylvania (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hugh D. Sington</i>		ADDRESS Glen Burnie, Maryland		24a. REGD BY REGISTRAR FEB 13 1957		24b. REGISTRAR'S SIGNATURE <i>Oldenbach</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BY MONITOR-HIGH-SCHOOL STATE EXAMINER

CERTIFICATE OF NEVADA

James L. Smith

W. H. C.

1

Y. S.

1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1430

CERTIFICATE OF DEATH

01438

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A.CO., Md.</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u>		b. COUNTY <u>A.A.Co., Md.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harmons</u>		c. LENGTH OF STAY IN 1b <u>50Yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Harmons</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harmons, Md.</u>		d. STREET ADDRESS <u>Harmons, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Ernest</u>		First	Middle	Lost	4. DATE OF DEATH <u>2/2/57</u>	Month	Day	Year <u>19</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/10/ 1865</u>		9. AGE (In years lost birthday yrs.) <u>91</u>	IF UNDER 1 YEAR: Months <u>11</u>	IF UNDER 24 HRS.: Days <u>0</u>	Hours <u>0</u>	Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Charles County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Harrison Watts, Harmons, Maryland</u>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Insuff.</u> 475X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <u>Upper Respiratory Infection</u> DUE TO (c)									
INTERVAL BETWEEN ONSET AND DEATH <u>1/2/56</u> <u>to 2/2/57</u> <u>11 mths.</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Sensitivity</u>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>1150 P.M.</u>		20f. (City or town) <u>Harmons</u>		(County) <u>Charles</u>	(State) <u>Md.</u>
21. I certify that I attended the deceased from <u>Jan. 3, 1957</u> , to <u>Feb. 2, 1957</u> , that I last saw the deceased alive on <u>Feb. 2, 1957</u> , and that death occurred at <u>1150 P.M.</u> from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>Frank E. Shipley</u>		ADDRESS (Street, city or town, state) <u>Savage, Md.</u>							
PHYSICIAN'S NAME (Type) <u>Frank E. Shipley</u>		DATE SIGNED <u>2/3/57</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/6/57</u>		22c. NAME OF CEMETERY OR CREMATORIUM <u>St. Rest Cemetery</u>		22d. LOCATION (City, town, or county) <u>Harmons, Maryland</u>		(State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles R. Law, 802 Madison Avenue.</u>				ADDRESS		24a. REC'D BY REGISTRAR <u>FEB 6 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Frank E. Shipley</u>	

BUREAU V. S.

FEB 6 1957

RECEIVED